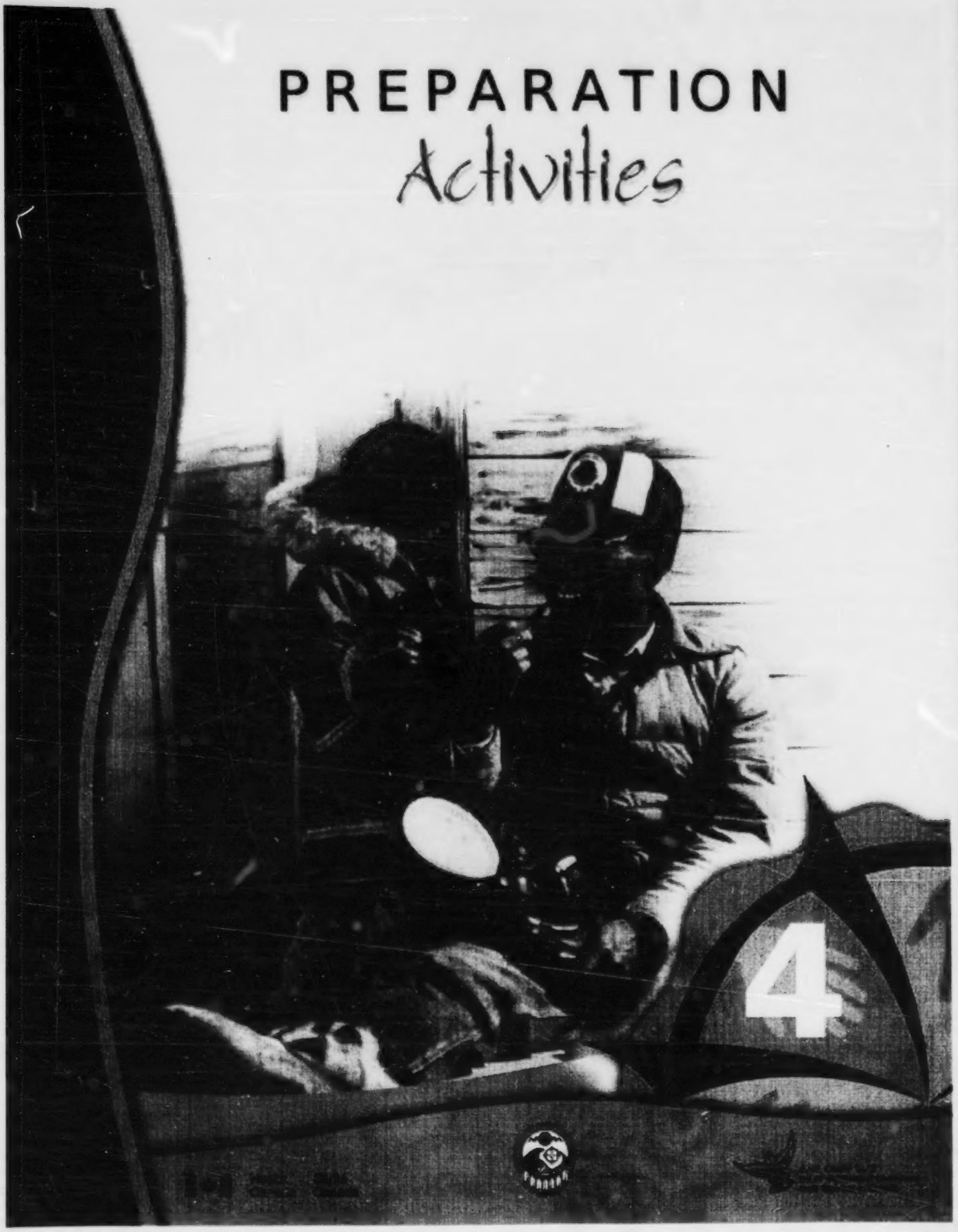
PREPARATION

Activities



101-04437/

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Health Canada

Également disponible en français sous le titre Guide de planification - Soins à domicile et en milieu communautaire des Premières Nations et des Inuits.

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Medical Services Branch National Clearinghouse
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Ottawa ON K1A 0L3

This document is available on the Health Canada website: http://www.hc-sc.gc.ca/msb and the Assembly of First Nations website: www.afn.ca

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Cat. No. H34-105/2000-4E
ISBN: 0-662-28522-0

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ABOUT THIS HANDBOOK

Purpose

Handbook 4 provides details about the activities that communities will need to undertake to prepare for full program service delivery for the Home and Community Care Program.

The Handbook is intended for community/tribal council/regional Inuit association planners and regional First Nations and Inuit organizations.

Using this Handbook

This Handbook is a guide. The steps outlined in the Handbook do not need to be followed in every way. Its goal is to support – not replace – the essential process of determining what will work best in your community. Importantly, the Handbook promotes the integration of community beliefs and values into the design of the program. In this regard, ***select the examples and suggestions in the Handbook that reflect the values in your community and are most appropriate for meeting your community's particular needs.***

The aim of the planning and development process is:

- to build an effective Home and Community Care Program;
- to provide services that meet the needs of community members;
- to ensure that the services can be provided as long as they are needed; and
- to establish a foundation for making the program better as the years go by.

The planning and development process for your Home and Community Care Program is designed to be community based and community paced.

This process is an ever evolving process that will ensure that home and community care services will continually seek new and innovative ways and means of responding to the identified needs in each First Nations and Inuit community.

INTRODUCTION

The preparation activities for program delivery is the last step in the planning process and the first step in program service delivery. In other words it is the "bridging phase" between planning and full implementation. This phase can take anywhere from 3 to 12 months depending on the priorities established by the community, the infrastructure in place, and the amount of funding available. At the end of this phase, most training will have been completed, policies and procedures developed, staff oriented, service delivery tools developed and tested, data collection tools in place and so on. **The importance of this "bridging phase" should not be minimized.**

It will be important during this phase to manage service delivery expectations. As in your planning process, you will need to keep community members informed of your activities and progress so they understand what needs to occur before service delivery happens.

PREPARATION ACTIVITIES

Set Up Workplan

A workplan will assist you in carrying out your preparation activities. It will also be used as the basis for putting in place a contribution agreement with the funding agency.

A sample workplan is attached as Appendix A.

The following are suggested steps in setting up your workplan.

1. Identify all the **major activities** that need to get done.
2. Prioritize the activities.
3. Identify all the **tasks** that need to get done in order to accomplish the major activities.
4. Identify who will carry out the tasks (**person responsible**).
5. Where a **cost** is involved, identify the amount of resources you will need to carry out the tasks within your overall budget.
6. Set reasonable **timelines** to get the work done. As you develop your workplan and set timelines against each task, you may find that some tasks will only take a short amount of time while others may take several months. Your timelines should therefore be realistic and take into account the difficulty and size of the task and the amount of resources available.

In your workplan, identify the major activities that need to get done, the tasks required to accomplish the activities, who will carry out the work, associated costs (if applicable), and the timelines to get the work done.

The following are *examples* of **major activities** that should be in place prior to full program service delivery. Review the list against what is in place in your community and adjust by adding activities as necessary.

Develop and/or Adapt Policies

Policy development is a key governance responsibility. There are two key areas where policies need to be developed: **program and personnel.** Any new policy development should be consistent with existing policies.

It is not necessary to develop policies from scratch, at least not at the beginning. Gather information from the province/territory, home care agencies in your region, and/or other First Nations/Inuit communities about the policies they use in their Home and Community Care Program. Decide which policies you will need to put in place and use them as is or adapt the policies to meet the specific needs of your community.

An outcome to policy development is the development of the procedures associated with each of the policies. Procedures provide the technical description for how staff are suppose to carry out the policy. Usually procedures are drafted after the policies have been developed.

All policies and procedures should be approved by the management structure before they are put into practice.

Once approved, it is recommended that policies and procedures be organized and kept together in a binder. It is also recommended that in-service orientations be held for staff to inform them about the policies and procedures. The Coordinator for the Program is responsible for ensuring that the program operates in a manner that is consistent with the policies approved by the management structure.

Program Policies

Sample program policies will be available on the MSB and AFN websites in the Spring of 2000.

Program policies provide the framework for everything that the program does and supports the day to day operation of services such as what to do when a client is not home, what to do if there is an unsafe situation, reporting procedures, etc. As such, one of the most important activities that you will carry out is the development and monitoring of program policies. Key policy areas include:

- the administration and financial management of the program;
- guidelines for recruiting, training and managing the staff;
- guidelines and procedures for delivering the services, for example:
    - eligibility criteria
    - policy to guide service priorities and limits
    - service contracts to outside agencies (links to additional services)
    - provision of service to family members
    - role of family members or the informal care giver
    - clients rights
    - charting and record keeping

- incident reporting
- presence of client when service is given
- entering client's home when there is no response
- client's house keys to staff
- death in the home
- appeal processes
- reporting of abuse
- storm plans and inclement weather policies
- universal precautions
- employee health (including required immunizations)
- employee safety
- sexual harrassement
- sharps disposal (needles, etc.)
- needle puncture injuries
- transportation of clients
- client confidentiality
- storage of client records
- access and security of files
- definition of heavy cleaning
- provision of personal care by home health aides

Personnel Policies

The following policies should be established:

- salary levels, benefits and hours of work
- professional registration and licensing
- professional supervision for nursing procedures and personal care
- confidentiality of medical records
- occupational health and safety policies and safeguards
- code of ethics
- conflict of interest

First Nations transferred communities have developed personnel policies as part of their community health plan. Gather examples of personnel policies from a transferred community.

Sample personnel policies are attached as Appendix B.

Obtain Liability and Malpractice Insurance

Liability and malpractice insurance needs to be in place and appropriate to cover the employer and its staff who will be delivering services under the new program.

Develop Job Descriptions

Sample job descriptions and performance appraisal forms are attached as Appendix C.

Once you have decided on the staff you will require (refer to Handbook 3A and your Service Delivery Plan), develop a detailed job description including the educational and experience requirements of the job, and a performance appraisal format for each position. Again, gather work descriptions from other agencies, First Nations/Inuit communities that are delivering similar services. Review them to see what aspects are appropriate and adapt as necessary.

Recruit, Select and Orientate Staff

A good recruitment, selection and orientation process for staff ensures that you can deliver high quality services to your community members.

Establish Client Records and Tools

Establishing client records and service tools before program delivery occurs is critical. They will provide the necessary supports to care providers to effectively carry out their work, they will document necessary information about each client and their needs, they will ensure proper and ongoing care to the client, and they will serve as a source of information for program monitoring and reporting.

You will want to make sure that the client records and service tools you develop are user friendly, culturally appropriate, respond to the needs of your community, and where there are strong links with provincial/territorial services that your client records and tools are "compatible".

The following are examples of basic client records and tools that may be part of a Home and Community Care Program:

- request for service
- home care admission form
- continuation sheet/narrative
- client assessment tool
- medication record
- home care plan or home care contract
- task list
- physician's order
- procedures flow sheet
- home health aide monthly record
- screening tool for priority care
- home care body picture
- nursing database for client assessment
- discharge summary sheet

A sample client record file is attached as Appendix D.

Set Up Client Assessment Process

During the client assessment review, you will want to make sure that the form you use to assess the individual's service needs takes into account his or her physical, mental, emotional and spiritual health. All of these aspects come into play when determining what home and community care services will best support that person.

The form should be set up to encourage a relaxed conversation between the home care nurse or assessor and the individual who is requesting service and their informal caregiver. It will be on the basis of this information that you collect that the home care nurse, the home care coordinator and the rest of the health and social services team develop a plan for care which includes the types of services and their frequency. The plan for care is discussed with the individual and is revised as necessary before it is put into practice. The nurse and/or home care coordinator review the plan with the client from time to time. Together, they make whatever changes may be necessary, in consultation with other staff who are part of the health social service team.

Sample client assessment tools and care plans are attached as Appendix E.

Establish Roles and Responsibilities

Your Service Delivery Plan described how the roles and responsibilities between the home care nurse and community nursing (health centre/nursing station) functions, and the adult care workers/home health aides and community health representatives functions will differ. Identify the tasks needed to formalize the roles and responsibilities and any changes or adjustments that may need to be made.

Formalize Program Linkages

Your Service Delivery Plan outlined a process for establishing client referrals and linkages to other services, programs, care providers and agencies and funding linkages to other programs and services. It is important to make sure linkages are properly established and defined in order to make the best use of your program resources and services and ultimately provide the best care to your community members. Identify the tasks that need to be carried out to make the linkages happen.

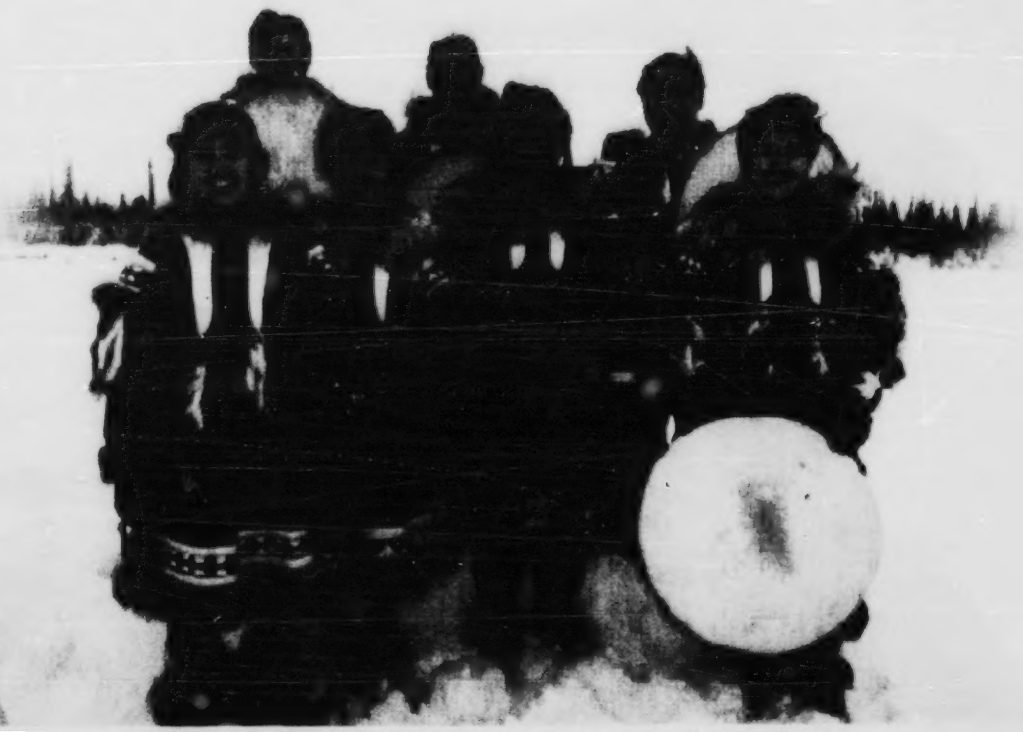
Establish Data Collection and Program Monitoring

In your workplan, identify all the tasks that need to be done to establish your data collection system and set up your program monitoring system, who will carry out the work, associated costs (if applicable), and timelines to complete the work.

Obtain Medical Supplies and Equipment

In your workplan, identify all the tasks that need to be done to obtain medical equipment and supplies on an ongoing and as needed basis, who will carry out the work, associated costs (if applicable), and timelines to complete the work.

Sample statistical data collection tools are attached as Appendix F.



Monitor/Report on Progress

Once your workplan is established, identify a process for monitoring its progress and for adjusting timelines if necessary. Some suggestions might be to set up weekly or monthly meetings with the planning team to report on the status of each task. Another suggestion is to assign one person to keep track of all assigned tasks and progress against them. Your management structure will also need to be kept up to date and may require something more formal like a written progress report. The reporting requirements against the contribution agreement/integrated agreement will also dictate how often and the method of reporting on progress to the funding agency.

Monitor/Report on Budget

In addition to monitoring and reporting the progress against program activities, you will also need to monitor and report the financial activities of the program and spending forecasts for each plan. Again, identify a process for doing this. Review the reporting requirements against the contribution agreement/integrated agreement to ensure you take into account the requirements of the funding agency.

Hold Community Meeting

Remember to keep community members informed about the progress of your activities and budget so they are aware and understand what needs to occur before service delivery happens. This will help to manage service delivery expectations.

All the best for a successful program!

APPENDICES

Appendix A - Sample Workplan

OBJECTIVE

Develop and/or Adopt Home and Community Care Program Policies and Procedures

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• identify which policies need to be developed and/or adapted			
• review existing policies to see if these can be used or adapted for the new program			
• gather information from the province/territory, home care agencies, and/or other First Nations/Inuit communities about the policies they use in their home and community care program			
• draft or adapt the policies (if necessary, bring in someone with policy expertise to provide advice and to assist in drafting and/or adapting the policies)			
• review and discuss each policy as it is developed at a full meeting of the management structure			
• approve the policies as they are completed			
• draft procedures for each policy			
• set up a "Policy Manual" to hold all policies as they are developed			
• conduct an in-service session to inform staff about the policies and procedures			

OBJECTIVE

Develop Personnel Policies

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• identify which policies need to be developed			
• gather information from other First Nations/Inuit communities about the policies they use			
• draft or adapt the policies (if necessary, bring in someone with policy expertise to provide advice and to assist in drafting and/or adapting the policies)			
• review and discuss each policy as it is developed at a full meeting of the management structure			
• approve the policies as they are completed			
• inform staff of policies			
• list other tasks			

OBJECTIVE

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• review existing coverage			
• purchase additional coverage (as required)			

OBJECTIVE

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• identify list of job descriptions to be developed and qualifications (education and experience) required for each			
• review existing work descriptions to see if these can be used or adapted for the new program			
• gather information from other First Nations/Inuit communities			
• draft or adapt the job descriptions			
• approve the job descriptions as they are completed			
• discuss and distribute to appropriate staff			
• list other tasks			

OBJECTIVE

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• initiate recruitment activities (write up advertisement, post)			
• set up interviews			
• hire staff			
• develop staff orientation manual			
• set up in-service session to orient new and existing staff on: program goals and objectives, policies, procedures, work functions, lines of supervision, etc.			
• list other tasks			

OBJECTIVE

Establish Client Records/Tools

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• identify the client records and tools that are needed			
• gather information from the province/territory, home care agencies, and/or other First Nations/Inuit communities about the client records they use in their home and community care program			
• develop or adapt client records/tools			
• hold in-service session to review client records/tools with care providers			
• test the use of tools			
• organize formal training session, if necessary (identify in Training Plan)			
• print copies of all records/forms			
• identify person responsible for maintaining supply and reprints			
• set up secure file system (separate or integrated system with nursing station/health centre) to hold completed client records			
• identify the people who will have access to file system			
• list other tasks			

OBJECTIVE

Develop Client Assessment Tool

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• review existing client assessment tools			
• adapt or develop tool			
• review with other care providers/agencies for "compatibility"			
• organize formal training session (identify in Training Plan) on interview techniques with client and family and on the use/completion of tool			
• test tool and revise as necessary			
• print copies			
• identify person responsible for maintaining supply and reprints			
• list other tasks			

OBJECTIVE

Establish Roles and Responsibilities

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• review job descriptions of home care staff			
• review job descriptions of existing community health staff, community health representatives, adult care workers			
• adjust job descriptions to remove any duplication of functions or to add new functions			
• hold sessions with all workers to communicate roles/responsibilities			
• hold regular team meetings with all workers as it relates to client care			
• list other tasks			

OBJECTIVE

Program Linkages

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• contact local hospital to establish discharge planning procedures			
• set up process for accessing expert services, e.g. Diabetes Educator, Dietitian, etc.			
• set up system and process with nursing station/health centre to maintain client records			
• establish a formal arrangement (e.g. Letter of Understanding) with other community based services for access to resources and services (e.g. NIHB medical supplies and equipment, Brighter Futures, Building Healthy Communities, DIAND Adult Care Program In-Home Component)			
• list other tasks			

OBJECTIVE

Data Collection and Program Monitoring

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• develop statistical reporting tool (likely paper base tool until information system can be developed)			
• set up in-service on use of tool			
• set up monthly service reporting			
• set up file system to maintain data			
• establish a plan for an annual review of services			
• establish a plan for implementing quality control activities			
• list other tasks			

OBJECTIVE

Medical Supplies and Equipment

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
• purchase home care nurse supply bag			
• identify list of daily supplies and equipment			
• arrange access for supplies and equipment			
• set up link with Non-Insured Health Benefit Program			
• set up purchase link with local Red Cross			
• list other tasks			

OBJECTIVE

Other Activities (list)

TASKS REQUIRED	PERSON RESPONSIBLE	COST	TIMELINE
•			
•			
•			
•			
•			
•			

Appendix B - Sample Personnel Policies[1]

The following provisions shall apply to all employees save and except where any Employee(s) are expressly secluded. Any violation of any provisions herein may result in disciplinary action.

Client Confidentiality

It is expected that all staff will respect client confidentiality based on the Oath of Confidentiality. Breaching confidentiality may result in disciplinary action up to and including dismissal. All staff will receive a copy of the confidentiality standards and guidelines.

There will be no sharing of client information in the job situation or at home. Anything you may know about the conditions or treatment of a client is strictly confidential.

Do not discuss client information with:

- one client about another
- visitors
- relatives and friends of the client
- representatives of the media
- your friends not involved in the client situation
- fellow workers

Should anyone request client information, direct him or her to the Home Care Coordinator.

[1] The following sample personnel policies have been obtained from a transferred First Nations community.

Under no circumstances will client information, particularly involving the use of names, be discussed by the staff in public places (e.g. band office, restaurants, bars, etc.).

Any information on a client can potentially be shared with the Home Care Coordinator as part of your regular duties. This includes structured Case Conferences with the Home Care Coordinator and fellow workers.

Information released to other agencies or team members will be at the discretion of the Home Care Coordinator. Any uncertainty will be clarified with the Home Care Coordinator.

Code of Ethics

"ETHICS" may be defined as the morally "right" types of behavior, which are expected of you on the job.

Telephone Calls

When you are working in a private home, you should not make personal calls. Use the phone, if necessary, only with the client's permission. Ensure your client is not being deprived of care because you are on the phone unnecessarily.

Gifts from Clients

You cannot accept gifts and/or money from clients or give gifts or money to a client. Never let yourself be accused of favoritism because of something you might gain from tending to one client's needs before another.

Accidents and Errors

When accidents happen or errors are made, you should report them immediately to the Home Care Coordinator. An accurate account at the time will protect you from false accusations and will allow corrections or treatment to be done right away to protect the client from further harm.

Confidential Information

All client information should be kept confidential in the job situation and at home. Anything you may know about the condition or treatment of the client is strictly confidential. This includes information about an individual or family's lifestyle, relationship, housekeeping standards or other observations you might make because of working in their home.

You should not discuss this information with anyone, inside or outside your job situation, except as part of your regular duties and in structured conferences with the Home Care Coordinator and/or fellow workers. Even in the health center, while having coffee, you don't know who will overhear something they shouldn't. It is important that you do not talk about your clients in a social situation or with your family.

When going from client to client, do not mention other client's names or any information about that client or your responsibilities in that situation.

Employee Conduct

Conduct of all Employees will be above reproach at all times, on and off standard hours of work.

All employees shall remain a satisfactory standard of dress and general appearance appropriate to their duties.

All employees are expected to conduct themselves in a courteous and professional manner at all times.

Employees shall keep all information, learned or acquired through their employment, strictly confidential.

Confidentiality

All information regarding the Council business is classified as confidential.

Any requests for information of a confidential nature must be addressed in writing to the Council.

No information of a confidential nature shall be released without the expressed written authorization of the Council of where allowed by the Council generally.

Any breach of confidentiality may result in disciplinary action.

Annual Job Performance Appraisal

All Managers will provide an annual written Job Performance Appraisal of all employees under their supervision.

The said Job Performance Appraisal shall be discussed and signed by the employee and the immediate Supervisor.

The said Job Performance Appraisal will be available to the Council upon request.

The Council shall do an annual written Job Performance Appraisal on the Directors.

All Job Performance Appraisals shall be filed with the Employees Personnel file annually.

Conflict of Interest

The Council may request any or all Employees for a complete business disclosure upon hiring.

Employees shall not enter into any business, partnership or undertaking that will conflict in any manner with his/her employment with the Council. Should any conflict arise, the Employee shall be subject to disciplinary action.

Driver's Licence

All Employees shall have a valid Driver's Licence with the appropriate classification pursuant to job requirements unless exempt in writing by the Council.

Each and every case where there is a loss of driving privileges, the Employee shall immediately notify the Council.

The Council is exempt from any and all liability resulting from any action during the period of the loss of driving privileges.

The Council will review the circumstances to determine the continuance of employment for the Employee who may lose his/her employment as a result of losing driving privileges.

Salaries/Increment

All salaries of Employees shall be paid in accordance with the terms and conditions of the employment.

All employees shall be paid every second Friday with the exception of short term Employees and they should be paid as negotiated.

The Council is not obligated to make deductions unless required by law or authorized by the Employee to do so.

Salary increases shall be based on a written and signed job performance appraisal of the Employee and it shall be at the discretion of the Council to grant a salary increase for an Employee subject to the availability of funds.

Hours of Work

With the exception of Managers, hours of work for Employees shall not exceed forty (40) hours per week.

The hours of work shall be from 8:30 a.m. until 4:30 p.m., with one hour allowed for lunch daily between the hours of 11:00 a.m. and 2:00 p.m.

There will be two (2) coffee breaks allowed per day and not to exceed fifteen (15) minutes per break.

First Nations Property

All First Nations property issued to Employees must be signed for and under no condition shall the Employee transfer the said property to any other Employee or any other party.

Any loss or damage to the said property directly attributable to negligence of the Employee shall result in his/her being required to repair or replace same.

Employees shall protect and care for all the First Nations property entrusted to them and shall return same upon termination of employment or request.

Reserve Elections

If an Employee is nominated for position for Chief or Council and the Employee accepts the nomination that Employee is not required to resign immediately from their position.

Right to Vote

In the event of a federal, provincial, First Nations community election, all Employees eligible or entitled to vote shall be allowed the necessary time with pay to attend the polls.

Holiday and Leave of Absences

The vacation year shall be the employee's anniversary date of employment.

Upon commencement of employment, an Employee must work ten (10) working days in order to be eligible for 1.25 day's holiday credit.

Thereafter, Employees shall earn 1.25 day's holiday credits per calendar month worked. Earned holidays credits must not exceed fifteen (15) working days in a fiscal year for any Employee who has less than 5 years.

All Employees are required to take earned holidays to the extent of earned credits and who have completed six (6) months of continuous employment. The Council has the right to instruct any Employee on when to use up their vacation time.

All requests for holidays must be approved in advance by the Council.

Should a Statutory Holiday fall on or during an Employee's holiday, the Employee shall be allowed to add another day to his/her holiday credits.

If an Employee takes unearned holidays, it will be regarded as a leave of absence without pay.

Earned holiday credits shall be taken and under no circumstances shall holiday credits be converted to a cash settlement except upon termination of employment.

Failure to take earned holiday credits which are earned in one vacation year shall result in a forfeiture of earned holiday credits if the earned holiday credits are not taken by the end of the following vacation year.

All Employees are entitled to request the status of earned holiday credits at any time and shall be notified in writing the amount of earned holiday credits they have earned by the end of the fiscal year by the Council.

All Employees shall use the ***Record of Time Off Sheet*** and sign the monthly summary sheet indicating their concurrence with the number of days off or earned credits.

Statutory Holidays

All Employees shall be entitled to the following holidays with pay:

New Year's Day	January 1st
Good Friday	
Easter Monday	
Victoria Day	May
Canada Day	July 1st
Labour Day	September
Thanksgiving Day	October
Remembrance Day	November 11th
Christmas Day	December 25th
Boxing Day	December 26th
Civic Holiday	1st Monday in August
Tribal Day	August 1st

If any of the above holidays fall on either Saturday or Sunday, the following Monday shall be observed as a holiday, except Remembrance Day, which shall be on November 11th with no alternative date.

The Chiefs and Council may, at their discretion and authority, declare day(s) within each calendar year as a tribal holiday(s) or to set aside as a tribal holiday(s) at which time the Administration offices, schools and affiliated organizations operating in the community may be obliged to follow.

Sick Leave

For the purpose of sick leave credits, days shall be equal to 7.5 hours.

Upon commencement of employment, an Employee must work ten (10) working days in order to be eligible of one (1) day's sick credit.

Sick leave shall be earned at the rate of one (1) day per month.

All Employees shall be entitled to a leave of absence with pay as a result of illness to the extent of accumulated sick leave days.

Any illness causing absence must be reported as soon as possible to the Council on the first day of illness. Failure to report will be regarded as a leave of absence without pay.

Any illness causing absence for any period of more that three (3) consecutive working days must be supported by a medical certificate to be given to the Council on the day the Employee returns to work.

Sick leave days shall accumulate during the period of employment to apply to cases of long-term illness. In such cases where an illness continues longer than accumulated sick leave days, application for Employee Insurance (E.I.) benefits must be made by the Employee.

Any employee who, for any reason, resigns or whose employment is terminated shall not be entitled to payment for accumulated sick leave credits.

Sick leave days, without medical certificate, must not exceed twelve (12) accumulated days in any one (1) fiscal year.

An excess of twelve (12) accumulated days, sick leave will be applied against earned holiday credits.

Medical appointments should be made so as to least interfere with hours of work.

Medical appointments exceeding four (4) hours, the time away from work shall be applied to either sick leave credits or compassionate leave.

Compassionate Leave

Upon commencement of employment, an Employee must work ten (10) working days in order to be eligible for compassionate leave.

All Employees shall be entitled to a leave of absence with pay for reasons of illness in the Employee's immediate family.

All requests for compassionate leave of absence shall be approved by the Council.

Compassionate leave shall not exceed twelve (12) days per fiscal year and further compassionate leave will be applied against earned holiday credits.

Bereavement Leave

For bereavement only, immediate family includes father-in-law and the mother-in-law of the employee and any relative on the employee's household or with whom the employee resides.

Upon commencement of employment, an Employee must work ten (10) working days in order to be eligible for bereavement leave.

All Employees shall be entitled to leave with pay in the event of a death in the Employee's immediate family.

An Employee so bereaved shall be entitled to no more than five (5) days leave with pay in each given circumstance.

Where it is warranted, additional two (2) days may be allowed for traveling but must be approved by the Council.

Maternity Leave

The Employee must have completed six (6) consecutive months of employment to be eligible for maternity leave to a maximum of seventeen (17) weeks.

The Employee must submit a written application to the Council at least four (4) weeks before the leave is to commence requesting maternity leave. She must also produce a doctor's certificate stating that she is pregnant and also stating the estimated date of delivery.

Maternity leave can commence no earlier that eleven (11) weeks prior to delivery or can last no longer than seventeen (17) weeks after the baby is born.

An Employee who has been granted maternity leave shall be permitted to apply up to a maximum of ten (10) days of her sick leave against E.I. waiting period.

If the Employee wishes to resume employment when the leave expires, the Employee must be reinstated in her former position or in a comparable job with the same wages and benefits.

After the delivery, the Employee shall notify the Council in writing if she desires to return to work. If the Employee fails to indicate within three (3) months whether or not she plans to return to work and she cannot provide a certificate from the attending physician advising that she is not physically capable of performing her responsibilities, she will be considered to have resigned her position. Employees are requested to give the earliest possible notice of intent.

Paternity Leave

An Employee shall be granted two (2) days paternity leave to be applicable on the day of the birth and on the day of discharge from the hospital.

Adoption Adjustment Leave

Adoption adjustment leave shall be treated as maternity leave except that the period of leave is twenty-four (24) weeks maximum.

Leave of Absence Without Pay

A leave of absence without pay may be granted upon written application to the Council. The application may be denied.

However, an Employee who is granted a leave of absence without pay greater than one (1) month shall be deemed to have resigned from his/her position at the discretion of the Council.

Court Leave

Any Employee subpoenaed to appear in court as a witness or who is called upon for jury duty shall be given the time off with pay to attend as required.

Any remuneration received from the court by the Employee shall be turned over to the Council.

Any Employee or their immediate family required to appear in court as a result of charges being laid shall be given a leave of absence without pay to attend as required.

Private Vehicles - Travel Reimbursement

Any Employee using his/her own vehicle for the First Nations business shall carry business insurance. This business insurance must include coverage of a minimum of one million ($1,000,000.00) dollars public liability and property damage. The cost of the business insurance, over and above the cost of All-Purpose Coverage, shall be recoverable from the Council if the Employee applies for it through normal claim procedures.

All eligible Employees using their own vehicles will be reimbursed a kilometer rate set by the Council.

It is the sole responsibility of the Employee to provide for the maintenance, major overhaul and the general up-keep of his/her own vehicle.

Accidents

Any Employee, who is faulted fifty per cent (50%) or more as a result of an accident in a First Nations owned and/or rented vehicle, shall be responsible for the deductible.

Convictions, which result in suspension of driver's licence, due to the Employee's negligence, may result in disciplinary action to the Employee if the driver's licence is essential in the performance of the Employee's duties.

All violations of speeding and parking tickets shall be the sole responsibility of the Employee.

Overtime

Overtime shall mean hours of work in excess of standard hours of work except where specific provisions of any agreement or document specifically override the provisions set out herein.

Standard Hours of Work

The standard hours of work for all Employees shall not exceed forty (40) hours per week.

The hours of work shall be from 8:30 a.m. until 4:30 p.m. with one (1) hour allowed for lunch daily between the hours of 11:00 a.m. and 2:00 p.m.

There will be two (2) coffee breaks allowed per day and not to exceed fifteen (15) minutes per break.

Overtime Guidelines

Managers are **not** eligible for overtime.

Employees, excluding managers, shall receive time off in lieu of overtime pay.

To qualify for overtime leave, an Employee must have worked a minimum of the standard hours of work **provided the Employee is requested to work overtime by the Council.**

In cases of emergency, Employees working beyond the standard hours of work, overtime and causes, must be reported as soon as possible to the Council.

No Employee, excluding Managers, shall work more than forty (40) overtime hours per fiscal year.

If any such overtime is required to be worked on Statutory Holidays, then for each part hour worked, the Employee shall accrue two (2) hours overtime leave or double time.

All overtime must be documented and substantiated by the Council.

Any Employee eligible for overtime leave must have prior approval by the Council in order to take overtime leave.

Time spent on travel to/from work or to/from destination beyond the standard hours of work while on Council is not deemed overtime.

Orientation

All new employees will be subject to orientation not to exceed one week, outlining the organization and the operation of the First Nations. This orientation is to be conducted by the Manager.

Initial Probation

Every Employee offered a full-time salaried position shall be automatically on an initial probation period of three (3) months.

If after this probation period, the Manager is satisfied with the work performance, the Employee shall be granted permanent status. A written review shall accompany any such decision.

If prior to the expiration of this probation period, the Manager is dissatisfied with the work performance and/or conduct, the Employee shall be:

- granted further specific period of probation; or
- be terminated from employment.

All recommendations for permanent status of an Employee will come from the Manager in writing to Council for approval within five (5) working days of the expiration of the probationary period.

All Employees, who have completed three (3) consecutive months of employment and have not received a notice stating that they have been terminated or that their position period is extended, can consider themselves to be a permanent Employee of the Council.

Each Employee placed on permanent status shall sign a contract; the contract will expire at fiscal year end.

The Manager shall notify in writing the appropriate Employee two (2) weeks prior to the expiration date of the probationary period.

Upon being placed on permanent status, every Employee may be issued a personal identification card with their most recent portrait.

Performance Deficiency Probation

In instances where a full-time employee's performance is not meeting the performance standards, the following action shall be taken by the Manager.

- Verbal warning; with a written notification of warning filed with the Manager.
- If unsatisfactory performance continues, a written notification shall be given to the Employee and a copy put on the Employee's personnel file.
- If unsatisfactory performance still continues, the Employee may be subject to suspension and/or dismissal by the Manager.

Casual/Term Employees

In instances where a casual/part-time Employee's performance is not meeting the performance standards, the following action shall be taken by the Manager:

- verbal warning; and/or
- the Employee may be subject to immediate dismissal by the Manager.

Contract Employees are subject to the terms and conditions of the contract.

Suspensions

Any Employee may be placed on suspension, without pay, for not satisfactorily performing his/her duties or for serious misconduct.

Notice of all suspensions shall be reported to the Council within forty-eight (48) hours giving justification for such action.

Appeals

Any Employee subject to disciplinary action shall have the right to appeal the decision to the Council. Procedures for launching an appeal shall be as follows:

- The Employee shall indicate in writing his/her decision to appeal the disciplinary action to Manager.
- The Manager shall acknowledge in writing the receipt of the notice to the Employee and forward all necessary and appropriate documentation to Council.
- The Manager shall arrange an appeal hearing between the Employee and Council within a period of time not to exceed fifteen (15) working days from the Manager's date of receipt of written decision from the Employee to appeal.
- Where an Employee's appeal is upheld, the Employee must be reinstated in his/her former position or in a comparable job with the same remuneration and benefits and the Employee shall not suffer any loss of pay or seniority.

Termination of Employment

Voluntary Termination of Employment

Any Employee, voluntarily resigning form his/her position of employment with the Council, shall give a written two (2) week notice of termination to the Manager.

- If an Employee resigns or has terminated his/her employment before completing one (1) year of work, the Employee shall be paid holiday pay at a rate established by the Canada Labour Board.
- Upon termination, all Council property shall be returned before any final payments in salary, severance and travel can be made.

Employees Who Have Been Employed Over Three Months But Less Than One Year

Any Employee who has completed three (3) consecutive months of employment and has not received a notice stating that they have been terminated or that their probation is extended can consider themselves to be a permanent Employee of the Council.

If the Employee has completed three (3) months of employment but not twelve (12) consecutive months, the Manager may terminate the employment by the following means:

- notice in writing, at least two (2) weeks before a date specified in the notice, of the manager's intention to terminate his/her employment; or
- two (2) weeks remuneration in lieu of such notice.

Layoffs

If the Manager decides that an Employee's services are no longer required due to lack of funds, the Manager may:

- Give adequate notice (one month) stating that effective on such a date, his/her services are no longer required by the Council;
- Allow them to use the phone to make calls regarding possible job positions and allow them to go to appointments during working hours;
- At the end of the notice period, pay them severance pay in accordance with the Canada Labour Code, that being:
  - two (2) days remuneration for each completed year of continuous employment with the Council; plus
  - five (5) days remuneration.

For Just Cause

Termination of employment for "just cause" is extremely difficult for the Manager to establish and extreme caution must be used in this type of termination. The Manager must establish repeated warnings, both of poor performance and of the specific steps required to upgrade his/her performance and must compare the Employee to all of his/her other Employees. An Employee who has been terminated before he/she was given a fair opportunity to demonstrate his/her real ability will be held to have been wrongfully dismissed.

- Any Employee may be dismissed for just cause.
- Those matters, which would allow the Manager to terminate an Employee, without notice of severance pay, are as follows:
    - serious misconduct;
    - habitual neglect of duty;
    - serious incompetence, not just Manager dissatisfaction with performance;
    - conduct incompatible with his/her duties or prejudicial to the company's business;
    - willful disobedience to a lawful and reasonable order of a superior on a matter of substance;
    - theft, fraud or dishonesty;
    - continual insolence and insubordination;
    - excessive absenteeism despite corrective counseling;
    - inadequate job performance over an extended period as a result of drug and alcohol abuse and failure to accept or respond to Manager's attempt to rehabilitate.

Where the manager dismisses an Employee for "just cause", the Employee who was dismissed, may make a request in writing to the Manager to be provided with a written statement giving the reasons for the dismissal, and the Manager shall provide the Employee who made the request with such a statement within fifteen (15) days after the request is made.

Any severance pay awarded shall be determined by the Manager.

Appendix C - Sample Job Descriptions[1]

Home and Community Care Director Job Description

General Description

The Home Care Director provides overall supervision and direction to the Home Care program and works under the supervision of the Executive Director as a member of the management team.

The Home Care Director combines her health knowledge, communication and administrative skills to effectively plan, direct, supervise and evaluate the delivery of home care services in such a way as to adapt to meet the changing home health needs of the band members.

Duties Related to Administration

To provide overall planning, direction, and evaluation for the Home Care Program so as to ensure the optimal level of services are available to meet the community's home health needs, while promoting client independence and community support.

To establish health care goals and objectives in consultation with community, staff and management team for the strategic planning of home care services which support the (name of community) vision statement.

[1] The following sample job descriptions were obtained from two First Nations communities.

To plan the effective organization of Home Care services in an innovative and adaptable manner in order to successfully manage the client's needs for optimal wellness in a culturally acceptable manner.

To develop, implement and evaluate home care policies and procedures for Home Care services to ensure that standards of care are consistently met.

To ensure that the Home Care policies, goals and philosophy are understood and adhered to by all staff.

To monitor the quality of care and initiate quality improvement measures for services provided by the Home Care Program.

To plan and oversee the collection of relevant data to be used for program planning.

To work effectively and cooperatively as a member of the management team.

To adapt and cope with changes in the work place so that new changes or situations can be mastered.

Duties Related to Administration

To effectively communicate program concerns and keep the Executive Director informed of developments in the workplace.

To provide the Executive Director with a written monthly report.

To prepare reports, proposals and perform any other related duties assigned by the Executive Director.

Build a productive, cooperative working climate within the team, the organization and with other community agencies.

Oversee the collection of statistical data and ensure that the funding agencies receive the required reports.

To oversee the budgetary needs and expenses of the Home Care Program.

Duties Related to Supervision Duties

To conduct performance appraisal within the probationary period and at least anually for the Home Care Staff which are supervised directly.

To identify and implement a continuing education plan to meet the ongoing professional needs of the staff.

To identify a human resource plan for future Home Care Program staffing needs.

To perform and enforce required verbal and written disciplinary measures involving Home Care Staff.

To approve all budgetary requests including: travel expenses; continuing education requests; purchase order requests; or overtime requests for Home Care staff.

Qualifications

Must be a registered nurse in good standing in a Canadian Province and to be able to attain registration with the (name of province/territory) Registered Nursing Association.

Previous working experience in Home Care and with First Nations.

Previous administration and supervisory experience.

Must have previous working experience with First Nations and have demonstrated understanding of the particular health and social issues encountered by First Nations.

Demonstrate excellent interpersonal and communication skills.

Minimum 4 years experience in nursing.

Valid drivers licence.

Home Care Nursing Supervisor Job Description

General Description

The Home Care Nursing Supervisor is a combined position of part-time nursing supervisor for the Home Care Program and part-time Home Care Nurse in the assigned community. She will act in place of the Home Care Director when the Director is absent as supervisor for the Home Health Aides and for the day to day operation of the (name of community) program.

The Home Care Nursing Supervisor works under the direct supervision of the Home Care Director and the general guidance of the Executive Director.

The Home Care Nursing Supervisor combines her/his health sciences knowledge with supervisory and clinical nursing skills to effectively provide and supervise client care.

The goal of the Home Care Nursing Supervisor is to coordinate the staffing and home care services in such a way as to meet the home care service needs of the clients effectively while encouraging client independence, family and community support.

The Home Care Nursing Supervisor will provide supervision of Home Care Nurses.

Duties Related to Acute Home Nursing Care

To utilize effective interpersonal communication skills in providing objective non-judgmental assessment of the client needs and to develop a goal based plan for care.

To provide acute nursing care to clients in their home based on physician instructions and as outlined in the Health Care Nurses Manual.

To continually assess the client's progress, using the nursing process, providing input for changes to the client's care plan.

To consult with the client's physician or others health care professionals as necessary to provide coordinated client care.

To provide information and teaching to clients or care givers on self care, preventative, rehabilitative and comfort measures.

To provide personal care to those clients whose condition is so unstable that it cannot be safely carried out by the Home Health Aide or the family.

To coordinate monthly Adult Health Clinics at the band level.

Supervision Duties

To supervise the Home Care Nurses, monitoring the quality and delivery of care.

To participate in the planning, development, and evaluation of the nursing programs.

To provide initial and ongoing field orientation of new nursing staff, ensuring that orientation is completed at a satisfactory level.

To complete written performance evaluation of the supervised staff, discussing results and recommendations with the Home Care Director.

To provide first line disciplinary action to the supervised staff in consultation with the Home Care Director.

To recommend for the supervised staff the employment leaves such as annual leave, education leave, etc.

To review nursing charting and month end reports ensuring that client care is safe, and based on established nursing goals.

To participate in the planning and provision of in-service to Home Care staff.

Maintain adequate medical supplies and recommends purchases of professional supplies as needed.

Other Related Duties

Maintain current nursing skills through attendance at workshops, in-service, and staff meetings, in addition to reading current literature in order to maintain awareness of services, techniques and equipment that may be of assistance to home care clients.

Meet weekly with the Home Care Director to review plans and activities, provide a written report to the Home Care Director monthly.

Provide clinical supervision to Home Care Staff for treatment procedures to ensure the safe performance of the procedure within the scope of nursing practice as outlined by the provincial association and the First Nations Home Care guidelines.

Bring to the attention of the Home Care Director if practices are not consistent with the current knowledge of acceptable professional standards.

Practice her/his job in a manner safe to both herself and the client.

Ensure that confidentiality as per First Nations Home Care Policy is maintained.

Participate in continuing education sessions as requested by First Nations Home Care.

Qualifications

A member in good standing with the (name of province/territory) Registered Nurses Association.

Preferred qualifications include one or more of the following:

- Baccalaureate degree in nursing from a Canadian University or recognized equivalent
- Certificate or diploma in nursing or community health nursing from a recognized post-secondary institution

Five years previous Home Care or Community Health work experience.

Previous supervisory experience in the health care field.

Must be self directed and have demonstrated organizational skills.

Maintain a valid (name of province/territory) driver's licence.

Excellent verbal and written communication skills.

Must have demonstrated ability in public relations and interpersonal skills.

Home Care Nursing Supervisor Monthly Routine

Check nurses charting each month.

Ensure client care covered or referred to family or other agencies when home care nurses are not available.

Make sure all nurses are using current doctor's orders.

Oversee nursing procedures to ensure safe practices.

Review nursing care plans periodically.

Assign short term nursing care if there is no possibility of long term care.

Inform Home Care Director when staffing cannot meet client care needs.

Review Home Health Aide reports.

Ensure that month end reports are submitted. Initiate additional monthly reports as required.

Make sure that calendars submitted and posted.

Vehicle reports for all staff are in by the 25th of each month.

Review and monitor leave forms to ensure all claims have been submitted.

Send the following directly to the Community Health Director for signing:

- expense claims; or
- leave and overtime requests.

Plan with Home Care Director the month end meetings.

Meet weekly with the Home Care Director.

Make a few visits with each nurse out to the community to observe and assist with client care each month.

Ensure that the chronic registry is kept up to date.

Review and make recommendations for improvements in policies and procedures.

Ensure that home care staff have proper equipment and supplies.

Home Care Nurse Assessor/Care Coordinator

General Description

The Home Care Nurse Assessor/Care Coordinator works under the direct supervision of the Home Care Director and the general guidance of the Executive Director.

The Home Care Nurse Assessor/Care Coordinator combines her/his health sciences knowledge with assessment, supervisory and clinical nursing skills to effectively assess, and coordinate client care.

The goal of the Home Care Nurse Assessor/Care Coordinator is to coordinate the staffing and home care services in such a way as to meet the home care service needs of the clients effectively while encouraging client independence, family and community support.

The Home Care Nurse Assessor/Care Coordinator will provide supervision of Home Care nurses and Home Health Aides.

Duties Related to Program Delivery: Assessment

Perform assessments and reassessments using the appropriate assessment tools while planning care with client and family to meet the client's health needs with in the budgetary constraints of the program. Interview members of the client's support system as required.

Utilize interpersonal communication, and written skills in providing an objective non-judgmental approach to client needs, and maintaining accurate client files.

Develop preliminary care plans for presentation to Assessment Review Committees.

Prepare task lists for each Home Management client with instructions for care for Home Health Aides.

Submit Home Care assessments, reviews and care plans to the Home Care Director.

Initiate emergency services when deemed necessary.

Consult with client's physician or other health agencies as necessary to provide client care.

Keep accurate client records and prepare month end reports of work done in a timely manner.

Supervision Duties

To supervise the Home Health Aides and Home Care Nurses, monitoring the quality and delivery of care.

To participate in the planning, development, and evaluation of the Home Health Aide and nursing programs.

To provide initial and ongoing field orientation of New Home Health Aide and Nursing Staff, ensuring that orientation is completed at a satisfactory level.

To complete written performance evaluation of the supervised staff, discussing results and recommendations with the Home Care Director.

To provide first line disciplinary action to the supervised in consultation with the Home Care Director.

To recommend for the supervised staff the employment leaves.

To assign client care based on assessed need, reviewing monthly calendar assisting in planning of client time. To review and sign monthly HHA stats.

To participate in the planing and provision of in-service to home care staff.

Other Related Duties

Maintain current nursing skills through attendance at workshops, in-service, and staff meetings, in addition to reading current literature in order to maintain awareness of services, techniques and equipment that may be of assistance to home care clients.

Meet weekly with the Home Care Director to review plans and activities.

Provide clinical supervision to Home Care Staff for treatment procedures to ensure the safe performance of the procedure within the scope of nursing practice as outlined by the provincial/territorial association and the First Nations/Inuit Home Care guidelines.

Bring to the attention of the Home Care Director if practices are not consistent with the current knowledge of acceptable professional standards.

Practice her job in a manner safe to both herself and the client.

Ensure that confidentiality as per First Nations Home Care Policy is maintained.

Participate in continuing education sessions as requested by First Nations Home Care.

Qualifications

A member in good standing with the (name of province/territory) Registered Nurses Association.

Preferred qualifications include one or more of the following:

- Baccalaureate degree in nursing from a Canadian University or recognized equivalent
- Certificate or diploma in nursing or community health nursing from a recognized post-secondary institution

Previous Home Care or Community Health work experience.

Must have demonstrated ability in public relations and interpersonal skills.

Must be self directed and have demonstrated organizational skills.

Maintain a valid (name of province/territory) driver's licence.

Excellent verbal and written communication skills.

Assessor Coordinator Monthly Routine

All new referrals for assessment contacted and screened within 24 hours with an appointment for assessment made if needed.

Reassess client care as health and support system changes.

Keep records of all clients who require yearly reassessment and perform a yearly reassessment for each client.

Assign short term nursing care if there is no possibility of long term care.

Ensure client care is covered.

Inform Home Care Director when staffing cannot meet client care needs.

Review Home Health Aide reports.

Month end report submitted.

Calendar submitted and posted.

Vehicle report by the 25th of each month.

Review and monitor leave forms to ensure all claims have been submitted.

Send the following directly to the Community Health Director for signing:

- expense claims
- leave and overtime requests

Plan with Home Care Director the month end meetings.

Home Care/Diabetes Educator Nurse Job Description

General Description

The Home Care Diabetes/Educator Nurse is responsible for providing community based acute care nursing services, and works under the direct supervision of the Home Care Director. The Home Care/Diabetes Educator Nurse uses her/his teaching, assessment, and nursing skills to effectively assist clients to attain their optimum level of independent functioning. All Home Care Nurses are involved in the delivery of acute home care nursing services, however additional areas of responsibility may be attached to the individual positions. Optional functions include, Chronic Care and Hospital Liaison responsibilities.

Duties Related to Acute Home Nursing Care

To utilize effective interpersonal communication skills in providing objective non-judgemental assessment of the client needs and to develop a goal based plan for care.

To provide acute nursing care to clients in their home based on physician instructions and as outlined in the Health Care Nurses Manual.

To continually assess the client's progress, using the nursing process, providing input for changes to the client's care plan.

To consult with the client's physician or other health care professionals as necessary to provide coordinated client care.

To provide information and teaching to clients or care givers on selfcare, preventative, rehabilitative and comfort measures.

To provide personal care to those clients whose condition is so unstable that it cannot be safely carried out by the Home Health Aide or the family.

To coordinate monthly wellness clinics at the band level.

General Responsibilities

To perform nursing assessments for all long term clients and prepare documentation for the proposed care plan.

To effectively organize Home Care services within the home in an innovative and adaptable manner in order to successfully manage the client's needs.

To maintain proficient client records and statistical monthly reports documenting services provided.

To maintain confidentiality of client information and files.

To provide support to the client and their family by acting as a resource as well as a professional liaison.

To maintain current nursing skills through attendance at workshops, in service sessions and staff meetings, in addition to reading appropriate literature to be aware of services, techniques, and equipment that may be of assistance to clients.

To practice her job in a safe manner to both herself and her clientele.

To ensure that (name of community) Home Care policies are adhered to.

To bring to the attention of the Director any practices which are not consistent with current knowledge or acceptable professional standards.

To be personally responsible for an assigned work vehicle its safe handling and ensure that the vehicle is maintained according to (name of community) policy.

To teach and supervise Home Health Aides providing personal care services.

Duties Related to Diabetic Education

To provide a comprehensive teaching and monitoring plan for newly diagnosed diabetic clients individualized to meet the needs, providing reassurance, teaching and support until the client is able to manage the diabetic regime independently .

To conduct or coordinate group diabetic education for secondary and tertiary prevention of the complications of diabetes.

Duties Related to Chronic Client Care

To make regular visits to adults with chronic conditions using the nursing process to assess the needs and develop a care plan based on realistic client centered goals.

To maintain and update the Chronic Conditions Registry according to (name of community) Home Care Policy.

To schedule visits to the well elderly based on goals and objectives for care.

Hospital Liaison Duties

Follow up (name of community) members admitted to hospital by visiting clients in hospital according to established schedule.

To act as a client advocate and liaison between the community care programs and (name of agency).

Provide a communication link with hospital staff and (name of agency) health services to ensure continuity of care between the institution and the community, meeting regularly with (name of agency/hospital) staff for discharge planning.

Provide liaison between the hospitalized clients of First Nations/Inuit ancestry and the Institutional health care providers in order to enhance the cultural sensitivity of the acute care services.

Identify the need for and orders aides for independent living required by the client prior to discharge.

Communicate the need for the necessary prescriptions and physicians instructions before discharge.

Qualifications

A member in good standing with the (name of province/territory) Registered Nurses Association.

Preferred qualifications include one or more of the following:

- Baccalaureate degree in nursing from a Canadian University or recognized equivalent,
- A certificate or diploma in nursing or community health nursing from a recognized post-secondary institution.

Previous Home Care or Community Health work experience

Must have demonstrated ability in public relations and interpersonal skills.

Must be self directed and have demonstrated organizational skills.

Maintain a valid driver's licence.

Excellent verbal and written communication skills.

Home Health Aide Job Description

General Description

The Home Health Aide is an integral part of the Home Care team, and works under the supervision of the Home Care Director. The Home Health Aide contributes to the health team through sharing thoughts, ideas and knowledge which may improve the quality of the client's care.

The objective of this position is to provide home management, personal care, and respite assistance to clients based on the assessed need. The goal is to promote the client's ability to live independently in a private home.

Duties Related to Program Delivery

To provide personal care as supervised by a registered nurse and according to the approved care plan. Personal care includes the following functions:

- Bathing and grooming
- Assistance with eating
- Simple bedside care
- Routine foot and nail care
- Getting ready for bed
- Maintaining medical regimes
- Toileting
- Dressing
- Transferring

- Activation
- Skin care
- Promoting self reliance

To provide household management assistance to the client according to the care plan. These services include the following general categories of work:

- Menu planning
- Mending
- Changing linen
- Laundry
- General household cleaning
- Budgeting
- Ironing
- Meal preparation

To provide attendant services or respite according to the care plan of the client for one of the following purposes:

- Supervision of clients who cannot be left alone
- Providing care to a very ill client in the home

Provide care to the client so that the caregiver can be given a break so that she/he can continue giving care on a long term basis.

Assisting the family to provide care for the dying in the home.

Provide assistance with meal planning and preparation, demonstrating knowledge of the client's special dietary and cultural needs while adhering to Canada's Food Guide.

Promotes independence of the clients by teaching either the client or the family in the area of self care.

Maintain accurate records of care given and health status changes observed in the clients. Observations of changes or accidents are to be reported immediately to supervisor.

Keeps knowledge current through attendance at training programs and workshops available.

Qualifications

Must be highly respected within the community.

Must have demonstrated ability to work well with others.

Must have demonstrated interest in caring for the elderly and disabled.

Must have demonstrated ability to accept supervision.

Must live on the reserve served.

Must have valid (name of province/territory) drivers licence and a vehicle at their disposal for home care work.

Should be a graduate from the Home Care/Special Care training program or be willing to take Home Care training.

Should have a telephone.

Must have a demonstrated ability to maintain confidential information.

Appendix C - Sample Job Description

Job Title: HOME CARE COORDINATOR

Purpose: To assess client's Home and Community Care needs, to plan, direct, evaluate and supervise the care required to meet these needs.

Major Job Task Description:	Measurement/Instrument:
Assessment: The Home Care Coordinator will complete a "Request for Service" form on all referrals; he/she will arrange a home visit with client and the "Informal Caregiver" to complete the "Assessment Tool." The Coordinator will assess the medical or functional need of each applicant for the Home and Community Care Program.	Each Client File will have a completed Request for Service form, a designated Informal Caregiver and a completed Assessment Tool. There will be a completed application form on the client's file for each continuing program the client will be attending.
Major Job Task Description:	**Measurement/Instrument:**
Plan: The Home Care Coordinator will determine the Plan of Care required based on the Assessment, the Physician's Orders and/or the Discharge Summary. A "Home Care Contract" or care plan will be completed by the Home Care Coordinator with the client and the Informal Caregiver's signature.	Each Client File will have updated Physician's Orders every 6 months and/or Discharge Summary following each admission to an Acute Care Facility. A Home Care contract will be on each Client file, signed by both the Home Care Coordinator and the Informal Caregiver.
Major Job Task Description:	**Measurement/Instrument:**
Directing the Care: The Home Care Coordinator will assign the necessary tasks to the appropriate staff. A copy of the Home Care Contract will be given to the staff providing the care and one will also be given to the Informal caregiver. Each staff member will be given a schedule of allotted time and dates for service to be provided to each client. Each client will be given a schedule at attendance at the Home and Community Care Program.	Each staff member will receive a schedule every 2 weeks. The Home Care Coordinator will ensure that all staff member's schedule was adhered to and the mileage record is correct, prior to the employee's payday every 2 weeks. The Home Care Coordinator will ensure that the proper reports are forwarded as required. (e.g. DIAND)

Job Title: HOME CARE COORDINATOR (continued)

Major Job Task Description:	Measurement/Instrument:
Evaluation of Care: The Home Care Coordinator will reassess the Care Plan whenever the client's condition changes, the client is hospitalized, the caregiver changes or at least every 3 months. The Home Care Coordinator will maintain communication with the staff and the informal caregiver to ensure client's needs are being met.	The Reassessment date will be recorded on the Assessment Tool.
Major Job Task Description:	**Measurement/Instrument:**
Supervision: The Home Care Coordinator will complete the Performance Appraisals on all Home and Community staff after the 3 month probationary period and annually thereafter. All Personnel Policies and Procedures are to be followed.	Each employee will have Performance Appraisals on their Personnel File.

Major Goals:

To Provide Home and Community Care Services to community members as required.

Date reviewed

Comments

Employee's Name: Date:

Supervisor's Name: Date:

Director's Name: Date:

Council's Name: Date:

Job Title: HOME HEALTH AIDE/PERSONAL CARE WORKER	
Activity	**Standards**
Function A: Provides Supportive Care to Client	
Supports/assists client in activities of daily living.	• Demonstrates knowledge of client's routine and lifestyle. • Encourages client independence in the performance of appropriate tasks. • Allows client to make own decision unless otherwise instructed. • Demonstrates empathy and kindness in communicating with the client and family. • Demonstrates an ability to listen objectively; to accept client's beliefs, values and lifestyle; and to take them into consideration when carrying out assignment. • Refrains from imposing own beliefs, values and lifestyle on client and family. • Demonstrates respectful behavior when providing care.
Function B: Provides Personal Care to Client	
Assists client with personal care as identified in care plan.	• Follows specific instructions in care plan and task sheet • Demonstrates use of safe body mechanics at all times. • Observes changes in client's physical condition and functioning and reports the changes to Home Care Coordinator.
Assists with ambulation, transfer and positioning.	• Demonstrates safe body mechanics at all times. • Encourages safe, effective use of walking aids and wheelchair. • Protects limbs from injury. • Demonstrates understanding of principals of prevention of skin breakdown and prevention of contracture when positioning client in bed.
Assists with feeding or feeds client as indicated in care plan.	• Demonstrates knowledge of client's past eating habits. • Prepares meals according to care plan. • Demonstrates knowledge and application of technique for prevention of choking. • Allows adequate time for chewing, providing for correct and comfortable positioning.
Ensures medication is taken as directed by care plan.	• Medication is taken as set out. • Records information as requested by Home Care Coordinator. • Reports to Home Care Coordinator changes in medication set up. • Ensures medication is properly stored as instructed.

Job Title: HOME HEALTH AIDE/PERSONAL CARE WORKER (continued)

Activity	Standards
Function C: Provides for the Elimination of Body Waste	
Assists client in toiletting.	• Prepares and cares for equipment to ensure safety and comfort of client. • Ensures privacy. • Positions client for comfort and safety. • Observes contents and reports observations to Home Care Coordinator as per instructions.
Function D: Provides Specially Authorized Personal Care	
Carries out specially authorized activities that require client specific training.	• Demonstrates knowledge and skill in performing specially authorized tasks. • Identifies specific ways one measures safety and comfort for client. • Applies safety and comfort measures in performance of tasks.
Function E: Prevents the Spread of Communicable Disease	
Follows program policy and procedures for maintaining a sanitary environment.	• Demonstrates a knowledge and application of guidelines/standards for maintaining a sanitary environment. • Follows guidelines for hand washing.
Follows communicable disease protocol for universal precautions for handling blood and body fluids.	• Demonstrates knowledge and application of communicable disease protocol and procedures for handling blood and body fluids. • Follows special procedures/directions as identified by Home Care Coordinator.
Function F: Provides Household Management and Laundry	
Maintains a safe and sanitary environment.	• Demonstrates knowledge and application of standards for safety and sanitation. • Follows specific instructions on the care plan and task sheet.
Function G: Provides for Client Nutritional Intake	
Assists with meal preparation according to care plan.	• Demonstrates knowledge and application of basic nutritional meals, special diets and food preferences of client. • Practices safe food preparation and storage practices.

Job Title: HOME HEALTH AIDE/PERSONAL CARE WORKER (continued)	
Activity	**Standards**
Function H: Organizes Work According to Client's Needs and Assigned Tasks	
Plans with client.	• Demonstrates knowledge of tasks. • Accommodates client's routine in work plan.
Priorizes assigned tasks.	• Plans the order in which tasks are performed. • Demonstrates ability to adapt tasks to the particulars of client situation.
Completes work assignment.	• Performs tasks according to instructions. • Reports to Home Care Coordinator when unable to carry out tasks.
Function I: Maintains Accountability	
Reports concerns in performance of tasks to Home Care Coordinator.	• Identifies knowledge and/or skill deficits.
Works within program guidelines.	• Demonstrates an understanding and application of program guidelines, procedures and practices.
Observes and reports significant changes to client situation.	• Demonstrates ability to record information on client's functioning as requested and reports to Home Care Coordinator.
Maintains client confidentiality.	• Ensures that client information is kept confidential at all times.
Completes and submits time sheets and mileage reports.	• Submits complete and accurate time sheets bi-weekly. • Submits mileage reports monthly.
Accident/Incident form is completed accurately according to instructions.	• Reports accidents/incidents immediately.
Uses supervision for problem solving clarification of assignment.	• Responsive to supervision visits. • Provides requested information. • Discusses suggestions made by Home Care Coordinator. • Reports concerns which impact on client's health and safety.

Job Title: LICENCED PRACTICAL NURSE	
Activity	**Standards**
Function A: Administers Direct Nursing Care Tasks, Legislated Under the LPN Act.	
Receives assignment with appropriate data from the Home Care Coordinator in relation to the authorized nursing care.	• Demonstrates an understanding of the data from the Home Care Coordinator. • Seeks additional data, if required, from the Home Care Coordinator.
Participates in the on-going data collection.	• Observes and collects data within the home situation. • Recognizes changes within the individual's health status. • Reports relevant data to the Home Care Coordinator.
Performs the nursing skill required to meet the assigned task.	• Explains the nursing task to the client and significant others. • Assists the Home Care Coordinator in actively involving the client and/or primary caregiver in carrying out assigned nursing tasks when appropriate. • Observes client's need for privacy. • Performs nursing tasks in a safe manner. • Reports changes in the client or client situation to the Home Care Coordinator.
Observes the results of the on-going assigned nursing tasks.	• Reports observed information regarding the effects of the nursing task to the Home Care Coordinator. • Involves the client and/or primary care-giver in obtaining data regarding the impact of the nursing task. • Assists the Home Care Coordinator in revising the plan for the nursing task when appropriate. • Implements the authorized revised nursing task.

Job Title: LICENCED PRACTICAL NURSE (continued)	
Activity	**Standards**
Function B: Provides for Accountability	
Reporting to the Home Care Coordinator.	• Immediately reports concerns to ensure safety and minimal health risk to client. • Reports any changes in the client's functioning or in the environment that may affect the client. • Participates in on going case review with the Home Care Coordinator as indicated in the care plan.
Recording.	• Recording is done per program policies. • Recording indicates case consultation and results of same. • Maintains confidentiality.
Use of supervision.	• Utilizes supervision to clarify role, activity and program guidelines. • Participates in the identification of learning needs. • Works with supervisor to meet identified needs within agreed upon time frames.
Works within program guidelines.	• Reinforces program, philosophy and objectives to clients and family. • Directs inquiries for further program information to the Home Care Coordinator.
Function C: Manages Workload	
Carries out work assignment.	• Notifies Home Care Coordinator or designate of days when available to work. • Participates in scheduling assignments with Home Care Coordinator or supervisor in order to arrive at a work schedule that meets client needs. • Notifies Home Care Coordinator or supervisor immediately when unable to carry out assignments. • Notifies client when unable to carry out assignments.
Completes required forms for financial reimbursement.	• Submits mileage claim on a monthly basis. • Submits time sheets bi-weekly.

PERFORMANCE APPRAISAL FORM
Confidential

Home Health Aide/Personal Care Worker Name: _____

Assessment Date: _____ Date of Hire: _____

Frequency & Hours of Service: _____ Assessed at: _____

Assessed by: _____

Activity	Standards	Exceeds	Meets	Does not Meet
Function A: Provides Supportive Care to Client				
Supports/ assists client in activities of daily living.	• Demonstrates knowledge of client's routine and lifestyle.			
	• Encourages client independence in the performance of appropriate tasks.			
	• Allows client to make own decision unless otherwise instructed.			
	• Demonstrates empathy and kindness in communicating with the client and family.			
	• Demonstrates an ability to listen objectively; to accept client's beliefs, values and lifestyle; and to take them into consideration when carrying out assignment.			
	• Refrains from imposing own beliefs, values and lifestyle on client and family.			
	• Demonstrates respectful behavior when providing care.			
Function B: Provides Personal Care to Client				
Assists client with personal care as identified in care plan.	• Follows specific instructions in care plan and task sheet.			
	• Demonstrates use of safe body mechanics at all times.			
	• Observes changes in client's physical condition and reports changes to Home Care Coordinator.			
Assists with ambulation, transfer and positioning.	• Demonstrates safe body mechanics at all times.			
	• Encourages safe, effective use of walking aids and wheelchair.			
	• Protects limbs from injury.			
	• Demonstrates understanding of principles of prevention of skin breakdown and prevention of contracture when positioning client in bed.			

Activity	Standards	Exceeds	Meets	Does not Meet
Function B: Provides Personal Care to Client (continued)				
Assists with feeding or feeds client as indicated in care plan.	• Demonstrates knowledge of client's eating habits.			
	• Prepares meals according to care plan.			
	• Demonstrates knowledge and application of techniques for prevention of choking.			
	• Allows adequate time for chewing, providing for correct and comfortable positioning.			
Ensures medication is taken as directed by care plan.	• Medication is taken as set out.			
	• Records information as requested by Home Care Coordinator.			
	• Reports to Home Care Coordinator changes in medication set up.			
	• Ensures medication is properly stored as instructed.			
Function C: Provides for the Elimination of Body Waste				
Assists client in toiletting.	• Prepares and cares for equipment to ensure safety and comfort of client.			
	• Ensures privacy.			
	• Positions client for comfort and safety.			
	• Observes contents and reports observations to Coordinator as per instructions.			
Function D: Provides Specially Authorized Personal Care				
Carries out specially authorized activities that require client specific training.	• Demonstrates knowledge and skill in performing specially authorized tasks.			
	• Identifies specific ways one ensures safety and comfort for client.			
	• Applies safety and comfort measures in performance of tasks.			

Activity	Standards	Exceeds	Meets	Does not Meet
Function E: Prevents the Spread of Communicable Disease				
Follows program policy and procedures for maintaining a sanitary environment.	• Demonstrates a knowledge and application of guidelines/standards for maintaining a sanitary environment. • Follows guidelines for hand washing.			
Follows communicable disease protocol for universal precautions for handling blood and body fluids.	• Demonstrates knowledge and application of communicable disease protocol and procedures for handling blood and body fluids. • Follows special procedures/directions as identified by the Home Care Coordinator.			
Function F: Provides Household Management and Laundry				
Maintains a safe and sanitary environment.	• Demonstrates knowledge and application of standards for safety and sanitation. • Follows specific instruction on care plan and task sheet.			
Function G: Provides For Client Nutritional Intake				
Assists with meal preparation according to care plan.	• Demonstrates knowledge and application of basic nutritional meals, special diets and food preferences of client. • Practices safe food preparation and storage practices.			
Function H: Organizes Work According to Client's Needs and Assigned Tasks				
Plans with client.	• Demonstrates knowledge of tasks. • Accommodates client's routine in work plan.			
Priorizes assigned tasks.	• Plans the order in which tasks are performed. • Demonstrates ability to adapt tasks to the particulars of client situation.			
Completes work assignment.	• Performs tasks according to instructions. • Reports to Home Care Coordinator when unable to carry out tasks.			

Activity	Standards	Exceeds	Meets	Does not Meet
Function I: Maintains Accountability				
Reports concerns in performance of tasks to Home Care Coordinator.	• Identifies knowledge and/or skill deficits.			
Works within program guidelines.	• Demonstrates an understanding and application of program guidelines, procedures and practices.			
Observes and reports significant changes to client situation.	• Demonstrates ability to record information on client's functioning as requested and reports to Home Care Coordinator.			
Maintains client confidentiality.	• Ensures that client information is kept confidential.			
Completes and submits time sheets and mileage reports.	• Submits complete and accurate time sheets bi-weekly. • Submits mileage reports monthly.			
Accident/ incident form is completed accurately according to instructions.	• Reports accidents/incidents immediately.			
Supervision for problem solving/ clarification of assignment.	• Responsive to supervision visits.			
	• Provides requested information.			
	• Discusses suggestions made by Home Care Coordinator.			
	• Reports concerns which impact on client's health and safety.			
	TOTALS			

Assessor's Comments:

Training Needs (as identified by the assessor):

Recommended Follow-up:

I have seen this performance appraisal and have discussed it with my supervisor

_____ _____

Employee Signature Date

_____ _____

Assessor's Signature Date

Home Care Assessment

Code

A. General Information

Band/Settlement:_____

Assessor: _____ Date: _____ (dd/mm/yy)

Place of Assessment ❒ Client's Home ❒ Other (specify)_____

Information provided by:_____

B. Client Profile

Name: _____

Band/Settlement: _____

Address: _____

Directions: _____

Other Address: _____

Telephone Number: _____

Party Line: ❒ Yes #_____ ❒ No

Do you have a neighbor where messages can be left?

❒ Yes #_____ ❒ No

Name: _____

Telephone Number: _____

Referred by: ❒ Self ❒ Family ❒ Physician

Other:_____

_____

Date of Birth:_____

Age: _____ ❒ Male ❒ Female

Languages Spoken:_____

_____

Provincial/Territorial Health No.:_____

Band/Inuit Id. No.:_____

Old Age Security No.:_____

Marital Status:

❒ Single ❒ Married

❒ Common law/Partner ❒ Widowed

❒ Divorced/Separated ❒ RecentStatusChange

Significant Allergies:_____

_____

C. Persons to Notify in Case of Emergency

Closest Family Member

Name: _____

Address: _____

Telephone Number: Work _____

Home _____

Relation to Client: _____

Band Office Telephone Number: _____

(Lifeline)

Emergency Response Number

Name: _____

Address: _____

Telephone Number: Work _____

Home _____

Relation to Client: _____

Health Centre/Nursing Station Telephone Number: _____

D. Client Physicians

Physician: _____

Location: _____

_____

Telephone Number:_____

Specialist	City

Code

E. Living Arrangements

❒ Lives alone or

Name: _____ Relationship: _____

F. Client Statement

Will you tell me what kind of help you need and why you need this help?

G. Physical Environment

Assessment Data	Comments of assessor and/or client
1. What type of residence does person live in (house, elders'lodge, etc.) Does the house have stairs? ❒ yes ❒ no	
2. How does the client do the following? **Heat house** ❒ Wood ❒ Oil ❒ Electricity ❒ Propane ❒ Other_____	
Cook ❒ Wood ❒ Electricity ❒ Other _____	
Get Water ❒ Hauls own water ❒ Has running water ❒ Family hauls water ❒ Water delivered	
Toilet Facilities ❒ Flush toilet ❒ Outhouse ❒ Chemical toilet ❒ Indoor Pail	
Laundry ❒ By hand ❒ Laundromat ❒ Has own appliance ❒ Other _____	

E. Living Arrangements (Update)

Date:	Date:	Date:

F. Client Statement (Update)

G. Physical Environment (Update)

Date:	Date:	Date:

Code

H. Physical Health

Do you have any health problems that limit your normal activity?

WT. B.P. Temp. Pulse Resp.

1. ❒ Diabetes
2. ❒ Arthritis or Rheumatism
3. ❒ Emphysema or Bronchitis
4. ❒ Heart or Circulatory Problems
   ❒ Pacemaker
5. ❒ Cancer
6. ❒ Muscular/Neurological disorders
   (eg. Effects of Stroke, Epilepsy)
7. ❒ Operations
8. ❒ Accidents/injuries
9. ❒ Other:

What problems does this create of the client?

I. Have you been hospitalized recently?

❒ Yes ❒ No
❒ Recovery Complete or:

Hospital stays in last 12 months	Reason	Length of stay	Discharge Date

Code

H. Physical Health (Update)

Date:	Date:	Date:

I. Hospital Stays (Update)

Hospital stays in the last 12 months	Reason	Length of stay	Discharge Date

Code

J. Current or Recent Medication

Which drug store do you usually use:_____

Prescription Drug	Dosage/Route	Purpose	Physician	Date Drug Started
Type of injections received				
Non-prescription items				

Are any of medications given to you by someone else. ❒ **Yes** ❒ **No**
If yes, who assists you taking which drugs listed above?

_____

_____

Treatments: Radiation, Physio, Other:

_____

_____

_____

K. Do you have allergies?

❒ **Yes** ❒ **No**

List:_____

_____

(What makes you sick and what type of reaction do you have?)

88

Food:_____

Medications: _____

Other: _____

J. Current or Recent Medication (Update)

Date: Medications:	Date:	Date:

K. Do you have allergies? (Update)

Code	L. Assessment Data	
	Assessment Data	**Comments of assessor and/or client**
	1.Nutrition What do you eat? Are there any foods that disagree with you? If yes what food?_____ Are you on a special diet? ❒ Yes ❒ No Are you following the diet? ❒ Yes ❒ No Who prescribed the diet?_____	
	2. Elimination Bowel Bladder Continent ❒ ❒ Occasional Problems ❒ ❒ Frequent Problems ❒ ❒ Incontinent ❒ ❒	
	3. Respiration Do you have trouble breathing? Do you have a persistent cough? (Describe) _____ Is oxygen equipment used? Do you smoke? ❒ Yes ❒ No	
	4. Skin and Circulation Do you have any skin condition problems? _____ Do you have any problems with your hands and/or feet? (check re: footcare)	
	5. Eyesight ❒ Good ❒ Fair ❒ Poor ❒ Partly or totally blind Can you see numbers on the telephone?_____ Glasses ❒ Yes ❒ No When and Where were glasses obtained? _____ Date last seen by eye specialist?_____	
	6. Hearing ❒ Good ❒ Fair ❒ Poor ❒ Partly or totally deaf Hearing aid ❒ Right ❒ Left ❒ No Type of batteries used and where are they normally obtained?_____ Date and Place Hearing Aid obtained? _____ Date and Place last hearing test completed? _____	
	7. Oral/Dental ❒ Own teeth ❒ Dentures ❒ Upper ❒ Lower ❒ Partial Do you have any problems with chewing, swallowing or sore gums? ❒ yes ❒ no Date last received dentures:_____	

L. Assessment Data (Update)

Date: **Nutrition:**	Date:	Date:
Elimination:		
Respiratory System:		
Skin and Circulation:		
Eyesight:		
Hearing:		
Oral/Dental:		

Code	L. Assessment Data (continued)	
	Assessment Data	**Comments of assessor and/or client**
	8. Mobility/Physical Abilities Do you have difficulty walking? ❒ Yes ❒ No If yes, is the difficulty ❒ Outdoors ❒ Indoors How do you get to places you cannot walk? ❒ Drives self ❒ Taxi ❒ Friend drives ❒ Family drives ❒ Other Is there anything else that keeps you from going out and getting about?_____ **Summary of Aids used:** ❒ Walker ❒ Cane ❒ Crutches ❒ Wheelchair ❒ Prosthesis ❒ Bathroom assists ❒ Other_____ Equipment and Aides required:_____	
	9. Social and Emotional Health What type of contact do you have with family, friends, community activities. _____ _____ _____ What are some activities you enjoy (interests/hobbies). _____ _____ _____ What interests/skills would you like to share? (teach Beading) _____ _____ _____	
	10. Do you see any of the following: ❒ Community Health Representative ❒ Community Health Nurse ❒ Mental Health Worker ❒ Social Worker ❒ Other:_____	

L. Assessment Data (Update)

Date: **Mobility/Physical Abilities:**	Date:	Date:
Summary of Aides used:		
Social and Emotional Health:		
Other support workers:		

Code	M. Activities of Daily Living	
	Assessment Data	Comments of assessor and/or client
	1. Light housework? (dishes, etc.) ❒ does without help ❒ limited ❒ unable **2. Heavy housework?** (floor, etc.) ❒ does without help ❒ limited ❒ unable **3. Laundry?** ❒ does without help ❒ limited ❒ unable **4. Preparation of hot meals?** ❒ does without help ❒ limited ❒ unable **5. Shopping?** ❒ does without help ❒ limited ❒ unable **6. Personal financial affairs?** ❒ does without help ❒ limited ❒ unable **7. Bathing?** ❒ does without help ❒ limited ❒ unable **8. Care of hair?** ❒ does without help ❒ limited ❒ unable **9. Dressing and undressing?** ❒ does without help ❒ limited ❒ unable **10.Eating/feeding?** ❒ does without help ❒ limited ❒ unable **11. Sleeping?** ❒ no problems ❒ some problems ❒ significant problems **Currently using medication for sleep?** ❒ yes ❒ no? **12. If you have a telephone can you use it?** ❒ yes ❒ no	
94	N. Family and Friends Who Help Client	Type and Frequency of Help

M. Activities of Daily Living (Update)

Date:	Date:	Date:

N. Family and Friends Who Help Client (Update)

Date:	Date:	Date:

Code

Do I have your permission to share the information you have given me with other health care professionals and/or family members and for assessment review?

❒ **Yes** ❒ **No**

Recommended services agreed upon by client assessor.

Date: **Assessor's Intuitive Observations and other relevant informations.**

O. Permission to Share Information: (Update)

Date:	Date:	Date:

P. Service Agreement: (Update)

Date:	Date:	Date:

Q. Case Notes: (Update)

Date:	Date:	Date:

Code

R. Assessor's Summary:

(Write comments regarding the person's ability in each of the following areas.)

1. Environmental Health (living conditions, household tasks, etc)

2. Physical Health (ability to communicate, personal care, etc.)

3. Mental Health
(Describe client's level alertness, memory, judgement, attitude, morale, cooperativeness)

4. Social/Spiritual Health (support system, spiritual values/beliefs, etc.)

5. Referrals recommended:

R. Assessor's Summary: (Update)

Date:	Date:	Date:

Code

S. Assessor's Observations and Comments:

1. **Explain any changes that have occurred in the client's circumstances recently. How is this affecting the need for services?**

2. **Are there any special factors that need to be considered if service is provided (confusion, attitude of client, memory loss, etc.)**

T. Recommended Service Based on Contract:

Nursing Diagnosis/ Statement of Problem	Type and frequency of service required	Objectives of Service (include timeframe)

100

S. Assessor's Observations and Comments: (Update)

Date:	Date:	Date:

T. Recommended Service Based on Contract: (Update)

Date:	Date:	Date:

Home Care Program Care Assessment

Coordinator _____ Date _____

Applicant's Name _____ Band/Inuit I.D.# _____

Band/Settlement _____ _____

Address _____ Phone No. _____

Type of Assessment • Admission • Reassessment Postal Code _____

Physician _____ Pharmacy _____

Family Information and Functional Assessment

Who lives in the same household with the applicant? (If none, write "none" in space.)

Name	Age	Relationship	Remarks

List relevant family members (If none, write "none" in space.)

Please mark (x) Next of Kin or local person responsible	Remarks: Indicate distance, frequency of contact, supportiveness of applicant and how.
Name Address Phone	
Name Address Phone	
Name Address Phone	
Name Address Phone	

Any additional information/assessment re: family functioning pertinent to assessment for / delivery of in-home care: _____

_____

Health Information / Health Functional Assessment

Clinical History:_____

_____

_____

_____

Major Clinical Findings / Diagnosis / Extent of Disability

_____

_____

Diagnosis Known To Family • Yes • No To Client • Yes • No

Allergies: If any, describe

_____

_____

Medication	Dosage	Frequency	Route	Prescribed By	Date

Ability to Administer • Independent • Requires Assistance (specify)

Compliance:_____

_____

Current prescribed treatments: If any, indicate applicant's ability to manage own treatment. • Independent • Requires Assistance (specify)

_____

_____

Have clinical findings / treatment been confirmed with attending physician?

• Yes (indicate how) • No (indicate plan for the confirmation)

_____ _____

_____

Nutrition: Is applicant eating adequately • Yes • No (specify)

Is applicant on special diet Yes No (specify) • Yes • No (specify)

Comments:_____

Any additional information / assessment re: physical health functioning pertinent to the assessment for / delivery of home care:

_____

ASSESSMENT FACTORS	NORMAL	PROBLEMS	REQUIREMENTS
Care compliance			
Problem solving			
Family supports			
Mental stability			
Mental orientation			
Mood			
Motivation			
Judgement			
Safety at risk			
Space adequacy			
Household cleaning			
Water available			
Heating			
Waste disposal			
Home repairs			
Home modifications			
Yard care			
Refrigeration			
Laundry			
Clothes drying			
Toilet			
Bathtub/shower			
Manages own affairs			
Ministers own meds			
Manages own treatment			
Spiritual health			
Financial situation			
Community support			
Helpful friend(s)			

ASSESSMENT FACTORS	NORMAL	PROBLEMS	REQUIREMENTS
Bathing - hygiene			
Hair management			
Dresses self			
Skin integrity			
Foot care			
Hearing			
Verbal communication			
Vision			
Telephone access			
Bladder function			
Bowel functioning			
Toileting ability			
Feeding ability			
Meal preparation			
Grocery shopping			
Diet adequacy			
General mobility			
Able to transfer			
Able to travel			
Social outlets			
Leisure activities			
Sleep / rest adequate			
Exercise / fitness			
Physical strength			
Physical function			
Health perception			
Health knowledge			
Motor skills			

SUMMARY ASSESSMENT

Under the following headings, indicate the area (s) (if any) where the applicant cannot meet need through self-functioning or through the services of available family or others, and which, if the need is not met:

- places the applicant at risk of not being able to remain in the community, or
- places the applicant at risk of deterioration which could directly contribute toward inability to remain in the community.

Where the applicant's ability to remain in the community is dependent upon the services of others in the household or in the community, show where the relief of such providers is realistically indicated for continued living in the community.

Household Maintenance Needs:

_____

_____

Health Needs:

_____

_____

Personal Care Needs:

_____

_____

Psycho/Social Needs:

_____

_____

Supplies/Equipment Needs:

_____

_____

Proposed Date for Re-assessment:

_____

_____

Signature of Assessor:

_____

_____

HOME CARE PROGRAM CARE PLAN

Client Name: _____ **Allergies:** _____

Band/Settlement: _____ **Diagnosis:** ❑ Code 1 ❑ Code 2

Date of Birth: _____ **Review Date:** _____

Sex: _____ **Level of Care:** 1 2 3 4 5

Band/Inuit I.D. #: _____ **Independence:** _____

Address: _____ **Support:** _____

Doctor: _____ **Type of Care:** _____

Provincial/Territorial Health #: _____

Home Care Services

Type of Service	Frequency	Type of Service	Frequency
❑ Nursing		❑ Meal Preparation	
❑ Personal Care		❑ Respite Care	
❑ Home Management			

Presenting Problems	Goal Desired Outcomes	Target Date	Met/ Unmet	Client/Family/ Other Responsibilities	Home Care Responsibilities

HOME CARE CONTRACT

Client's Name: _____

Primary (or Informal) Care giver: _____

Phone:_____

Presenting Problem	Tasks Required	By Whom	When

Signature of client and/or Primary (Informal) Care giver involved_____

- Home Care Services are provided to assist clients and family to remain living independently as long as possible.
- If you wish any changes to this contract for services please call the Home Care Coordinator

Date of Reassessment:_____

Signature of Home Care Coordinator:_____ **Date:** _____

Appendix F - Data Collection Tools - **Sample 1**

Instructions for First Nations and Inuit Basic Home and Community Care Monthly Statistics

Recording monthly work done is not only a requirement for funding, but is a valuable tool for supervising staff, and program planning. Monthly reports record the care received by each client by type of service and the amount of time provided by each care giver.

Each staff should fill out their own form for the month from their time sheets or client files and submit within the first week of the next month.

There are three sheets provided:

1) the Home Support Statistics to be filled out by each Home Health Aide/Personal Care Worker, and
2) the Nursing and Case Management Statistics sheet to be filled out by the nurse or the nurse assessor, and
3) the Total Program Statistics.

The Home Care Director or Coordinator may wish to compile the data from all staff on the Total Program Statistics sheet which will show all the services provided to each client from all the Home Care Staff.

Overview of the Report Form(s)

The forms have four main sections.

Section 1 - Client Information
This consists of columns A, B, C and D which are descriptors of the client who is receiving the service.

Section 2 - Home Visits
This consists of columns E, F, G and includes all visits to a client's home.

Section 3 - Home Support Time, Case Management Time and Nursing Time
This includes columns H, I, J, K, L, M, N, O, P, and Q which describe the services provided to each client in time and type of care provided (e.g. home support time, case management time and nursing time).

Section 4 - Total Client Time and Non-Client Time
This includes column R which on each sheet is the total time provided to a client, and column S which describes the staff time that does not directly relate to a particular client.

How to Record Time

- Do not record any time less than 15 minutes.
- When recording time, use decimals to indicate partial hours.

For 15 minutes	.25
For 30 minutes	.5
For 45 minutes	.75
For 1 hour of time	1

Section 1 - Client Information

A - Client Identifier

Each client should be assigned a confidential number which cannot identify them to an outside person or agency. This number should be kept by the Home and Community Care Program in a locked cabinet. No one outside the program should be able to identify the person receiving the services on the month end sheets. The number should only be assigned once. If a client is discharged or deceased, the number should not be reused.

B - Age Code

The age codes are listed below. The appropriate code can be circled to make filling out the form easier.

Age Codes

A - under 15
B - 15 - 44
C - 45 - 64
D - 65 and over

C - Sex

Circle the M if the client is male and F is the client is female.

D - Primary Diagnosis Code

Select from the Home Care diagnosis codes (page 124) the category which best describes why the client is receiving services. For example a person may be a frail elderly, but did not require services until she fell and broke her hip. In this case the primary reason for the service is the fracture.

Section 2 - Home Visits

This section is to be filled out in number of visits and not by time.

E - Home Visits

The home visits category includes all visits to a client's home including those in which home care service was provided.

F - Attempted Visits

Those times that the staff went to the client's home but no services was provided because the client was not home or other reasons such as refused service. Visits to the home of a client take time even when service is not provided.

G - Total Home Visits

The totals of columns E and F to give the total times the staff person went to the client's home in the month.

Section 3 - Home Support Time, Case Management Time and Nursing Time

Home Support Time

Home Support Time provides a record of home support services time for each client under the four main categories for home support services: Home Management, Personal Care and Respite Services, Meal Services, and Other Client Time related services.

H - Home Management

This includes the time spent doing home services for the client. It includes all cleaning, laundry, and seasonal cleaning.

I - Personal Care

Describes the time to provide personal care assistance with such activities as activation, rehabilitative exercises, bathing, foot care and hair care to a client.

J - Respite Services

This category includes time spent giving respite to a care giver.

K - Meal Services

This category captures the time spent assisting a client with meals through any of the following:

- preparing a meal for a client;
- bringing food to a client; or
- providing the client with a meal with others through a type of congregate dining or elders meal.

L - Other Client Time

This category includes time spent with arranging services for the clients, charting, reporting client needs to supervisor or other Home Care Staff, etc.

M - Total Home Support Time

The addition of the columns, H, I, J, K, and L gives the total hours of home support services provided to an individual client for the month.

Case Management Time

N - Assessment/Care Coordination

This time category is primarily for the Nurse Assessor, or the Case Manager. It includes the time spent visiting the client and supporters to assess the service needs, making the referrals and setting up the care to meet a client's health needs for home care services. The time category may include:

- visits to clients and support persons;
- charting;
- consulting with the physician(s);
- consulting with family members;
- case conferencing; and
- time required to set up all aspects of the service.

O - Case Management Code

The case management code will indicate the types of care a person has received from the case manager or nurse assessor. Circle the one or two codes which best describe the services provided in the month.

DC - Discharge Planning is the assistance with planning and assessing needs for equipment and support and care before discharge from a medical care facility. It may include case conferencing, hospital visits, equipment orders, etc.

IA - Initial Assessment is the first full assessment done for a client to determine the needs for care. It may be the first request for admission or a readmission of a previously discharged client.

RV - Reviews is the full or partial review of a clients health condition to ensure that the home care services are currently meeting the needs of the client, and to provide quality control of client care.

CC - Client Conferencing is the meeting with family, or health and/or other agencies such as social development to determine how care providers can best work together for the best care and support of a client.

HL - Hospital Liaison includes hospital visits and assistance to clients and staff in a medical facility to promote client care and communication.

OTR - Other care coordination services not listed above.

Home Nursing Time

P - Nursing Time

This time category captures all the activities related to providing nursing care to a particular client. The time includes direct patient care, travel to the client's home, all charting, referrals, and calls to physicians and other members of the health care team that relate to care for the client.

The Home care nursing service includes:

- performing nursing assessments;
- performing nursing treatments and procedures;
- providing on-going personal care when the Assessment specifies that the condition of the client is such that a nurse should perform the service;
- teaching and supervising self-care to clients who are receiving personal care or nursing services;
- teaching personal care to family members and other supporters;
- teaching and supervising home support staff providing personal care;
- initiating referrals to other agencies; and
- "Indirect Nursing Time" - other time spent which is related to a specific client:
    - charting
    - consulting with the physician(s)
    - consulting with family members
    - case conferencing
    - arranging for supplies, etc.
    - on-Reserve or community travel between clients

Q - Nursing Codes

These codes were developed in 1995 when Medical Services Branch first took on the mandate for home care nursing.

AP - Acute Post Hospital Care

Involves clients who are post-surgical or have had acute illnesses which has been diagnosed, treated and the client is stabilized. The Home Nursing Program would monitor the client's condition and ensure that the treatment is continued as per physician's instructions (e.g. Treatment of draining wounds, post cardiac surgery).

ST - Short Term Active Care

Acute care would provide home nursing care services to clients who are experiencing an acute illness, but have the potential for returning to a pre-illness level of functioning and self care. The main objective of a home care nursing program would be to control symptoms and prevent deterioration of the client (e.g. respirator, cardiac disease).

CA - Continuing Active Care

Time limited provides home care nursing to those clients with an illness/disability who will not return to their previous level of functioning, but will have the potential for increasing their level of functioning or self care, and will eventually function without home care nursing services. The home care nursing objective is to prevent deterioration and reach a maximum level of physical and social functioning without continued home care nursing services (e.g. burns, bowel/bladder problems).

SC - Sustaining Care

Would provide home nursing treatment services to clients with advanced disease(s) who cannot be maintained at home without ongoing home nursing care. The objective for this group is maintenance of a chronically ill client at home to their maximum level of functioning with ongoing home care nursing services (e.g. home dialysis, catheter maintenance).

PC - Palliative Care

Would provide home care nursing services for those clients with terminal illness. The objective of the nursing service is to enhance the client's comfort, dignity and quality of life and to eliminate and or control symptoms (e.g. HIV/AIDS, cancer).

Section 4 - Total Client Time and Non-Client Time

R - Total Client Time

The time that the client received from each care giver is totaled in this column to record the total home care services provided to the client during the reporting period.

Non-Client Time

S - Non-Client Time

This section describes how work time is used that is not directed towards a particular client, but is a valuable part of the program. It may also be used to track sick leave, education leave and annual leave.

Travel (Non Reserve)
Travel time to and from the community from the base office, travel to the local hospital or from one community to another is tracked in this category. The time it takes to travel between two clients in the community is tracked in the client time.

Annual Leave
This is the time that a staff takes off according to the employment policy.

Sick Leave
The time taken off by the staff because of illness. The amount of paid time allowed will be outlined in the employment policy.

In Service and Education Leave
Paid time for the staff to attend educational sessions, classes or workshops which will enhance the skills and knowledge relevant to the position.

Meetings
Time that the staff has spent attending meetings relevant to the position, such as interagency meetings.

Group Teaching Time
Time spent teaching, facilitating or participating in a group education session or clinic. Examples might be diabetes cooking classes, adult health clinics, Health Fairs, etc.

Preparation Time
The time spent preparing for a group teaching time.

Other Time
Time that is used in time other than those listed on the stats sheets. Please specify what the time was used for.

Supervision
Time spent relating to the supervision of another staff member or student. This includes:

- providing direction and guidance;
- assigning caseload;
- preparation time;
- actual time spent in the client's home doing hands-on supervision; and
- charting time.

Case Load

The box at the bottom of the page on the total program stats will indicate the number of clients admitted, discharged, readmitted during the month. The last category for inquiries will track the number of request for service that required screening, assistance, etc. but were not admitted to the program.

Education Sessions/Clinics

Record in this area the types of education sessions held during the month and the number who attended each session.

Home Care Diagnosis Codes

1-a	Conditions of the endocrine
1-b-1	Diabetes - diagnosed in past year
1-b-2	Diabetes - diagnosed over 1 year
1-b-3	Diabetic - newly put on insulin
1-b-4	Diabetes - gestational/pregnant diabetic
1-b-5	Diabetes - early signs of or existing renal disease
1-c	Hepatic, Biliary, and pancreatic
2-a	Cardiovascular disease/heart, circulatory
2-b	Cerebrovascular Disease and or CVA
3-a	Genitourinary Condition
3-b	Renal Condition
4-a	Gastrointestinal
4-b	Difficulty feeding (tube feeds, dysphagia, etc.)
5-a	Central Nervous System condition (MS, Parkinsonism, MD, CP)
5-b	Dementia, and related conditions (Alzheimer, etc.)
5-c	Mental/ emotional condition

6-a	Musculoskeletal condition - arthritis type condition
6-b	Musculoskeletal condition (fracture, amputation, etc.)
6-c	Musculoskeletal condition - other
7	Respiratory condition
8	Skin and subcutaneous condition
9	Communicable disease
10	Cancer
11	Frail elderly
12	Required Nursing Treatment not related to a diagnostic code
13	Accident victim
14	Severe blindness
15	Severe deafness
16	Autoimmune condition (lupus etc.)
17	Lack of diagnostic information
18	Other
19	Lifestyle related, e.g. addictions

Month End Report
First Nations and Inuit Home Care
Home Support Statistics

Community: _____

Staff Name: _____

Date: _____ Page ____ of ____

CLIENT INFORMATION				HOME VISITS			HOME SUPPORT TIME						NON-CLIENT TIME
Client Identifier	Age Code	Sex	Primary Diagnosis Code	Home Visits	Attempt Visits	Total Home Visits	Home Management	Personnal Care	Respite Services	Meal Services	Other Client Time	Total Home Support Time	
A	B	C	D	E	F	G	H	I	J	K	L	M	S
	A B C D	M F											Travel
	A B C D	M F											Annual Leave
	A B C D	M F											
	A B C D	M F											Sick Leave
	A B C D	M F											
	A B C D	M F											In Service and Education
	A B C D	M F											
	A B C D	M F											Meetings
	A B C D	M F											
	A B C D	M F											Group Teaching Time
	A B C D	M F											
	A B C D	M F											Preparation Time
	A B C D	M F											
	A B C D	M F											Other Time
	A B C D	M F											
	A B C D	M F											Supervision
	A B C D	M F											
	A B C D	M F											

Age Codes

A - under 15
B - 15 - 44
C - 45 - 64
D - 65 & over

Case Load	Program	Education Sessions/Clinics	Attendance
Admission			
Discharge			
Readmission			
Inquiries			
TOTALS			

Month End Report
First Nations and Inuit Home Care
Nursing Case Management Statistics

Community: _____

Staff Name: _____

Date: _____ Page ____ of ____

APPENDIX F - DATA COLLECTION TOOLS - SAMPLE 1

CLIENT INFORMATION				HOME VISITS			CASE MANAGEMENT		NURSING TIME		TOTAL CLIENT TIME	NON-CLIENT TIME
Client Identifier	Age Code	Sex	Primary Diagnosis Code	Home Visits	Attempt Visits	Total Home Visits	Asses/Care Coord Time	Case Management Code	Nursing Time	Nursing Code		
A	B	C	D	E	F	G	N	O	P	Q	R	S
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		Travel (Non Reserve)
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		Annual Leave
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		Sick Leave
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		In Service and Education
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		Meetings
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PCH		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		Group Teaching Time Preparation Time
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		Other Time Supervision
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PCH		
	A B C D	M F						DC IA RV CC HL OTR		AP ST CA SC PC		

Case Load	Program	Education Sessions/Clinics	Attendance
Admission			
Discharge			
Readmission			
Inquiries			
TOTALS			

Age Codes
- A - under 15
- B - 15 - 44
- C - 45 - 64
- D - 65 & over

Case Management Codes
- DC - Discharge Planning
- IA - Initial Assessment
- RV - Reviews
- CC - Client Conferencing
- HL - Hospital Liaison
- OTR - Other

Nursing Codes
- AP - Acute post hospital care
- ST - Short Term Active Care
- CA - Continuing Active Care
- SC - Sustaining Care
- PC - Palliative Care

Month End Report
First Nations and Inuit Home Care
Total Program Statistics

Community: _____

Staff Name: _____

Date: _____ Page ____ of ____

CLIENT INFORMATION				HOME VISITS			HOME SUPPORT TIME						CASE MANAGEMENT		NURSING TIME		TOTAL CLIENT TIME	NON-CLIENT TIME
Client Identifier	Age Code	Sex	Primery Diagnosis Code	Home Visits	Attempt Visits	Total Home Visits	Home Manage-ment	Personnal Care	Respite Services	Meal Services	Other Client Time	Total Home Support Time	Asses/Care Coord Time	Case Management Code	Nursing Time	Nursing Code		
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		Travel
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		Annual Leave
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		Sick Leave
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		In Service and Education
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		Meetings
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		Group Teaching Time
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		Preparation Time
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		Other Time
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		Supervision
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		
	A B C D	M F												DC IA RV CC HL OTR		AP ST CA SC PC		

Case Load	Program	Education Sessions/Clinics	Attendance
Admission			
Discharge			
Readmission			
Inquiries			
TOTALS			

Age Codes
- A - under 15
- B - 15 - 44
- C - 45 - 64
- D - 65 & over

Case Management Codes
- DC - Discharge Planning
- IA - Initial Assessment
- RV - Reviews
- CC - Client Conferencing
- HL - Hospital Liaison
- OTR - Other

Nursing Codes
- AP - Acute post hospital care
- ST - Short Term Active Care
- CA - Continuing Active Care
- SC - Sustaining Care
- PC - Palliative Care

Appendix F - Data Collection Tools - **Sample 2**

Instructions for First Nations and Inuit Simplified Home and Community Care Monthly Statistics

Recording monthly work done is not only a requirement for funding, but is a valuable tool for supervising staff, and program planning. Monthly reports record the care received by each client by type of service and the amount of time provided by each care giver.

Each staff should fill out their own form for the month from their time sheets or client files and submit within the first week of the next month.

There are three sheets provided:

1) the Home Support Statistics to be filled out by each Home Health Aide/Personal Care Worker,
2) the Nursing and Case Management Statistics sheet to be filled out by the nurse or the nurse assessor, and
3) the Total Program Statistics.

The Home Care Director or Coordinator may wish to compile the data from all staff on the Total Program Statistics sheet which will show all the services provided to each client from all the home care staff.

Overview of the Report Forms(s)

The forms have four main sections.

Section 1 - Client Information
This consists of columns A, B, and C which are descriptors of the client who is receiving the service.

Section 2 - Home Visits
This consists of column D and includes all visits to a client's home.

Section 3 - Home Support Time, Case Management Time and Home Nursing Time
This includes columns E, F, G, H, I, J, K, L and M which describe the services provided to each client in time and type of care provided (e.g. home support time, case management time and nursing time).

Section 4 - Total Client Time
This includes column N which on the sheets is the total time provided to a client.

How to Record Time

- Do not record any time less than 15 minutes.
- When recording time, use decimals to indicate partial hours.

For 15 minutes	.25
For 30 minutes	.5
For 45 minutes	.75
For 1 hour of time	1

Section 1 - Client Information

A - Client Identifier

Each client should be assigned a confidential number which cannot identify them to an outside person or agency. This number should be kept by the Home and Community Care Program in a locked cabinet. No one outside the program should be able to identify the person receiving the services on the month end sheets. The number should only be assigned once. If a client is discharged or deceased, the number should not be reused.

B - Age Code

The age codes are listed below. The appropriate code can be circled to make filling out the form easier.

Age Codes

A - under 15

B - 15 - 44

C - 45 - 64

D - 65 and over

C - Sex

Circle the M if the client is male and F is the client is female.

Section 2 - Home Visits

D - Total Home Visits

The home visits category includes all visits to a client's home including those in which no services was provided because the client was not home or other reasons such as refused service.

Section 3 - Home Support Time, Case Management Time and Nursing Time

Home Support Time

Home Support Time provides a record of home support services time for each client under the four main categories for home support services: Home Management, Personal Care and Respite Services, Meal Services, and Other Client Time related services.

E - Home Management

This includes the time spent doing home services for the client. It includes all cleaning, laundry, and seasonal cleaning.

F - Personal Care & Respite

This category includes time spent giving respite to a care giver, and providing personal care assistance with such activities as activation, rehabilitative exercises, bathing, foot care and hair care to a client.

G - Meal Services

This category captures the time spent assisting a client with meals through any of the following:

- preparing a meal for a client,
- bringing food to a client, or
- providing the client with a meal with others through a type of congregate dining or elders meal.

H - Other Client Related Time

This category includes time spent with arranging services for the clients, charting, reporting client needs to supervisor or other home care staff, etc.

I - Total Home Support Time

The addition of the columns, E, F, G, and H gives the total hours of home support services provided to an individual client for the month.

Case Management Time

I - Assessment/Care Coordination

This time category is primarily for the Nurse Assessor, or the Case Manager. It includes the time spent visiting the client and supporters to assess the service needs, making the referrals and setting up the care to meet a client's health needs for home care services. The time category may include:

- visits to clients and support persons;
- charting;
- consulting with the physician(s);
- consulting with family members;
- case conferencing; and
- time required to set up all aspects of the service.

K - Case Management Code

The case management code will indicate the types of care a person has received from the case manager or nurse assessor. Circle the one or two codes which best describe the services provided in the month.

DC - Discharge planning is the assistance with planning and assessing needs for equipment and support and care before discharge from a medical care facility. It may include: case conferencing, hospital visits, equipment orders, etc.

IA - Initial Assessment is the first full assessment done for a client to determine the needs for care. It may be the first request for admission or a readmission of a previously discharged client.

RV - Reviews is the full or partial review of a clients health condition to ensure that the home care services are currently meeting the needs of the client, and to provide quality control of client care.

CC - Client Conferencing is the meeting with family, or health and/or other agencies such as social development to determine how care providers can best work together for the best care and support of a client.

HL - Hospital Liaison includes hospital visits and assistance to clients and staff in a medical facility to promote client care and communication.

OTR - Other care coordination services not listed above.

Home Nursing Time

L - Nursing Time

This time category captures all the activities related to providing nursing care to a particular client. The time includes direct patient care, travel to the client's home, all charting, referrals, and calls to physicians and other members of the health care team that relate to care for the client.

The Home care nursing service includes:

- performing nursing assessments;
- performing nursing treatments and procedures
- providing on-going personal care when the Assessment specifies that the condition of the client is such that a nurse should perform the service;
- teaching and supervising self-care to clients who are receiving personal care or nursing services;
- teaching personal care to family members and other supporters;
- teaching and supervising home support staff providing personal care;
- initiating referrals to other agencies.
- indirect Nursing Time" - other time spent which is related to a specific client:
    - charting
    - consulting with the physician(s)
    - consulting with family members
    - case conferencing
    - arranging for supplies etc;
    - on-reserve or community travel between client's

M - Nursing Codes

These codes were developed in 1995 when Medical Services Branch first took on the mandate for home care nursing.

AP - Acute Post Hospital Care

Involves clients who are post-surgical or have had acute illnesses which has been diagnosed, treated and the client is stabilized. The Home Nursing Program would monitor the client's condition and ensure that the treatment is continued as per physician's instructions (eg. Treatment of draining wounds, post cardiac surgery).

ST - Short Term Active Care

Acute care would provide home nursing care services to clients who are experiencing an acute illness, but have the potential for returning to a pre-illness level of functioning and self care. The main objective of a home care nursing program would be to control symptoms and prevent deterioration of the client (e.g. respirator, cardiac disease).

CA - Continuing Active Care

Time limited provides home care nursing to those clients with an illness/disability who will not return to their previous level of functioning, but will have the potential for increasing their level of functioning or self care, and will eventually function without home care nursing services. The home care nursing objective to prevent deterioration and reach a maximum level of physical and social functioning without continued home care nursing services (e.g. burns, bowel/bladder problems).

SC - Sustaining Care

Would provide home nursing treatment services to clients with advanced disease(s) who cannot be maintained at home without ongoing home nursing care. The objective for this group is maintenance of a chronically ill client at home to their maximum level of functioning with ongoing home care nursing services (e.g. home dialysis, catheter maintenance).

PC - Palliative Care

Would provide home care nursing services for those clients with terminal illness. The objective of the nursing service is to enhance the client's comfort, dignity and quality of life and to eliminate and or control symptoms (e.g. HIV/AIDS, cancer).

N - Total Client Time

The time that the client received from each care giver is totalled in this column to record the total home care services provided to the client during the reporting period.

Month End Report
First Nations and Inuit Home Care
Home Support Statistics

Community: _____

Staff Name: _____

Date: _____ Page _____ of _____

CLIENT INFORMATION				HOME SUPPORT TIME				TOTAL HOME SUPPORT TIME
Client Identifier	Age Code	Sex	Total Home Visits	Home Management	Personal Care Respit	Meal Services	Other Client Time	
A	B	C	D	E	F	G	H	I
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						
	A B C D	M F						

Program	Number Clients
Admission	
Discharge	
TOTALS	

Age Codes
A - under 15
B - 15 - 44
C - 45 - 64
D - 65 & over

Month End Report
First Nations and Inuit Home Care
Nursing and Case Management Statistics

Community: _____

Staff Name: _____

Date: _____ Page _____ of _____

CLIENT INFORMATION				CASE MANAGEMENT		HOME NURSING TIME		TOTAL CLIENT TIME
Client Identifier	Age Code	Sex	Total Visits	Asses/Care Coord Time	Case Management Code	Nursing Time	Nursing Code	
A	B	C	D	J	K	L	M	N
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F			DC IA RV CC HL OTR		AP ST CA SC PC	
TOTAL					DC IA RV CC HL OTR		AP ST CA SC PC	

Program	Number Clients
Admission	
Discharge	
TOTALS	

Age Codes
- A - under 15
- B - 15 - 44
- C - 45 - 64
- D - 65 & over

Case Management Codes
- DC - Discharge Planning
- IA - Initial Assessment
- RV - Reviews
- CC - Client Conferencing
- HL - Hospital Liaison
- OTR - Other

Nursing Codes
- AP - Acute post hospital care
- ST - Short Term Active Care
- CA - Continuing Active Care
- SC - Sustaining Care
- PC - Palliative Care

Month End Report
First Nations and Inuit Home Care
Total Program Statistics

Community: _____

Staff Name: _____

Date: _____ Page ____ of ____

CLIENT INFORMATION				HOME SUPPORT TIME					CASE MANAGEMENT		HOME NURSING TIME		TOTAL CLIENT TIME
Client Identifier	Age Code	Sex	Total Visits	Home Management	Personnal Care & Respite	Meal Services	Other Client Time	Total Home Support Time	Asses/Care Coord Time	Case Management Code	Nursing Time	Nursing Code	
A	B	C	D	E	F	G	H	I	J	K	L	M	N
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
	A B C D	M F								DC IA RV CC HL OTR		AP ST CA SC PC	
TOTAL										DC IA RV CC HL OTR		AP ST CA SC PC	

Program	Number Clients
Admission	
Discharge	
TOTALS	

Age Codes
- A - under 15
- B - 15 - 44
- C - 45 - 64
- D - 65 & over

Case Management Codes
- DC - Discharge Planning
- IA - Initial Assessment
- RV - Reviews
- CC - Client Conferencing
- HL - Hospital Liaison
- OTR - Other

Nursing Codes
- AP - Acute post hospital care
- ST - Short Term Active Care
- CA - Continuing Active Care
- SC - Sustaining Care
- PC - Palliative Care